*Author:*
**Ash, Angie**

*Title:*
**Street level implementation of policy to protect elders from abuse : a case study of the dilemmas social workers and their managers face in a social services department**

# Street level implementation of policy to protect elders from abuse: a case study of the dilemmas social workers and their managers face in a social services department

**Angie Ash**

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## Abstract

National guidance to protect vulnerable elders from abuse was implemented in England and Wales from 2000. Local experience and early research indicated this multi-agency policy framework, coordinated by social services departments, was not always used by social workers when dealing with potential elder abuse.

This research aimed to identify factors influencing street level implementation by social workers of policy to protect elders from abuse. Critically deploying four elements of Lipsky's concept of street level bureaucracy (discretion, dissonance, workplace culture, and conflict and reciprocity between street level bureaucrats and managers), the research examined the understandings social workers and their managers had of intention and operation of procedures, and the dilemmas they faced in implementation.

A single case study design was used; the case was a social services department in Wales. The methods used were qualitative (semi-structured interviews, focus groups, observed meetings), with documentary and statistical analysis.

The research found social worker awareness of elder abuse and domestic violence in old age was low; 'seeing' elder abuse was restricted. Discretion was exercised in diffused, nuanced ways by many agencies, not one. The workplace culture was a network of agencies and professionals, rather than one place or team. Conflict between managers and street level bureaucrats was rare. A fragmented, complex, under-resourced service and regulatory framework was a 'visible/yet not visible' pressure on street level bureaucrats. Conceptually, street level bureaucrats wore 'cognitive masks' for protection from the dissonance arising from the structure and context of their work. These masks occluded 'seeing' elder abuse; they muted challenge of poor elder care.

The research concluded Lipsky's concept of street level bureaucracy provides continuing analytical traction to understand local policy implementation. However, Lipsky's thesis requires updating to understand 21st century street level implementation of policy to protect elders from abuse. The research locates where this revision is required.

# Dedication

*In loving memory of*

**Elizabeth Margery**

**1924 - 2005**

*May your bird now sing*

## Acknowledgements

I am grateful to the social workers and their managers in the case study site who contributed their experiences and views to this research. They were helpful, open and accommodating. It couldn't have been done without them.

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## Author's declaration

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original, except where indicated by special reference in the text, and no part of the dissertation has been submitted for any other academic award. Any views expressed in the dissertation are those of the author.

Signed.....

Date.....16 April 2009.....

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## Glossary

| | |
|---|---|
| AAPC | Area Adult Protection Committee |
| CSIW, CSSIW | 'CSIW' (Care Standards Inspectorate for Wales) and 'CSSIW' (Care and Social Services Inspectorate Wales) refer to the social care regulator in Wales. The respective functions and powers of the Care Standards Inspectorate for Wales and the Social Services Inspectorate for Wales were brought together on 1 April 2007, to form the Care and Social Services Inspectorate Wales. These had previously been separate inspectorates. |
| DSO | Designated Senior Officer |
| ECHR | European Convention on Human Rights |
| JCHR | Joint Committee on Human Rights |
| LHB | Local Health Board |
| NHSCC Act | NHS and Community Care Act 1990 |
| NMS | National Minimum Standards |
| POVA | Protection of Vulnerable Adults |

# Chapter 1 Introduction

## *Origins of the study*

The genesis of this study lies in happenstance. The abuse of elders, and other groups of vulnerable adults, became increasingly recognised in the UK in the 1990s (Slater and Eastman 1999). In 2000, governments in England and Wales issued guidance under Section 7 of the Local Authority Social Services Act 1970 (DH 2000; NAfW 2000). This required social services departments to coordinate policy development at the local level in cooperation with other agencies, including health, the police, regulators, service providers and independent sector interests. I was asked to work with fourteen agencies in one region of Wales to develop its multi-agency adult protection policy under this statutory guidance. This later led to my revising multi-agency policy and procedures in another Welsh region, and undertaking a series of case reviews across Wales involving the abuse of vulnerable adults, mostly elders.

Such serendipity was not unusual in the working life of an independent researcher, of which I was one. Each piece of work, and the discussions these involved with front-line staff, managers and policy makers in social services departments and other agencies, seemed to raise recurring themes. Adult protection policies required staff to implement adult protection procedures when abuse was disclosed, suspected or witnessed. This 'implementation' may not result in intervention or other action, but it required agencies to communicate under the procedures, pool information and agree a course of action (or non-action). However this did not always happen. Why, when faced with information about potential abuse, did social workers or their immediate managers in social services departments, not always implement multi-agency procedures to protect elders? Why were these cases sometimes managed 'informally', that is outside adult protection procedures or, conversely, with vague unspecified 'monitoring'? (AEA 2006). In short, why was there an apparent gap between the intentions of policy and its implementation?

These questions are the subject of this study, which started in 2005. Early research in England on adult protection policies developed under the English Section 7 guidance *No Secrets* found implementation to be erratic (Mathew *et al* 2002; Sumner 2004). Other work drew attention to the gap between policy intentions and social work

practice in protecting elders from abuse (Preston-Shoot and Wigley 2002), and to the state of flux of policy-making in elder abuse, with no answers about 'what works' (Manthorpe *et al* 2005).

Framing these findings was the contested debate in social work about the extent to which the community care reforms of the 1990s and increased professional regulation had undermined professional discretion. Evans and Harris (2004) proposed this debate broadly revolved around two differentiated strands: the *curtailment* of professional discretion or its *continuation*. The discretion social workers may exercise in using adult protection procedures to protect elders, the professional values and views they bring to bear to decisions on protection were therefore of interest in understanding *how* policies to protect elders at the local level are used. Evans and Harris (2004) suggested that the debate about discretion was informed, in part, by Dworkin's (1978) typology of 'strong' and 'weak' discretion, and by Michael Lipsky's (1980) thesis of street level bureaucracy. Lipsky had argued that the routines and devices street level bureaucrats (who included social workers) adopted in implementing public policies and managing the dilemmas inherent in their work, effectively became the policies actually implemented at the local level. This 'street-level approach' to examining policy implementation has been held to be particularly useful in situations involving discretion by front-line workers, and complex decision-making in a context of ambiguity and uncertainty (Brodkin 2000).

Lipsky developed his concept of street level bureaucracy in the US, four decades before this research was carried out. He used the term 'street level bureaucracies' to describe public agencies employing significant numbers of 'street level bureaucrats', who had direct contact with clients and "substantial discretion" (Lipsky 1980:3) in the way they worked. Within their ranks were, teachers, police, public lawyers and social workers. The exercise of discretion at the street level meant, Lipsky argued, that policy-making was insufficiently understood by looking at the actions of policy makers. Instead "in important ways (policy) is actually made in the crowded offices and daily encounters of street-level workers" (Lipsky 1980:xii), and that to

> understand how and why ... organizations often perform contrary to their own rules and goals, we need to know how the rules are experienced by workers in the organization and to what other pressures they are subject.
>
> *(Lipsky 1980:xi).*

Lipsky's thesis was, in essence, expressed thus:

> the decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out.
>
> *(Lipsky 1980:xii, emphasis in original).*

Pressman and Wildavsky (1984) had also recognised that problems with policy implementation could usefully be explored as the failure of policy makers to understand the values and definitions of the situation of those who actually implement the policy. Young (1981), too, had suggested that policy outcomes were determined by, firstly, the degree of control over the discretion of those implementing the policy and, secondly, the extent to which people share policy makers' definition of a situation.

However, with the exception of Preston-Shoot and Wigley (2002) little UK research attention appeared to have been paid in the early years of the 21st century to local implementation of policies to protect elders by social workers. In Wales, multi-agency adult protection policy and procedures had been developed by agency managers, adult protection committees and regional adult protection forums, who managed, supervised and monitored implementation. Drawing on Lipsky, this research set out to understand the dilemmas social workers faced when adult protection concerns about an older person were raised. In particular, it set out to understand the factors influencing social workers in their implementation of adult protection procedures to protect older people, and the extent to which social workers and their (policy-making) managers shared similar understandings of the intention and implementation of the procedures. Finally, the research wanted to consider what, if any, was the enduring legacy of Lipsky's concept of street level bureaucracy in terms of understanding the factors influencing street level implementation by social workers of procedures to protect elders from abuse.

## *Research questions*

This research addressed these issues and asked:

### Primary question

- What factors influence the street level implementation by social workers of policy to protect elders from abuse?

**Subsequent questions**

- What dilemmas do social workers and their team managers face in their implementation of procedures?
- Do agency policy makers, and social workers and their team managers, share similar understandings of the intention and operation of procedures?
- What impacts do these understandings have on local implementation in terms of:
  - exercise of professional power and discretion;
  - understanding and interpretation of the elder's situation; and
  - decision-making about action taken or not taken to protect an elder from abuse?
- What can Lipsky's concept of street level bureaucracy offer in understanding local implementation of policy to protect elders from abuse?

## *Structure of the study*

Chapter 2, which follows, develops the conceptual framework for the research. Here, four key propositions of Lipsky's framework of street level bureaucracy are examined, along with the UK policy context of statutory social work, and concepts of power and discretion are discussed. Chapter 3 reviews key UK literature on elder abuse, policy and research; it considers abuse 'thresholds', the concept of ageism and the human rights of older people. Chapter 4 describes the research methods, the case and the research design, and comments on the research process. Findings are presented in chapter 5. The implications of these are discussed in chapter 6, which returns to the research questions, considering these in light of findings. Finally, chapter 7 concludes the study. It identifies contributions the research makes to evaluating, developing and updating Lipsky's concept of street level bureaucracy, and to understanding street level implementation by social workers of policy to protect elders from abuse.

## A note on terms

**'Elders'** and **'older people'** are used interchangeably to avoid diversionary distractions about politically correct or incorrect forms of expression. While 'elder' is not a term most older people I have talked and worked with use or recognise, its

adoption here reflects its general use in research and campaigning. The issue is the abuse rather than labels, and it is there attention should lie.

**'Client', 'service users'** describe an elder who uses social services. They are used interchangeably, reflecting the term used by the writer or commentator.

**'Policy'** and **'procedures'** are differentiated thus: 'policy' refers to intentions and principles of agency documents; 'procedures' to the steps, actions, processes laid down for dealing with adult protection concerns. However, references in the literature and by agencies varies: I have attempted to use the term that most clearly describes what the text refers to, or the term used by the respondent. (Street level bureaucrats are charged with implementing policy *and* procedures).

**'National'** typically refers to the nation of Wales (as in 'national policy guidance'), as the research was carried out in Wales, and it concerned the adult protection policy framework of Wales. Where the policy or law of another UK nation is referred to, the country concerned is specified, for example the *Adult Support and Protection (Scotland) Act 2007* or 'the English adult protection policy guidance *No Secrets*'. Health and social care, along with many other policy areas, have been devolved matters in the UK since 1999. This report has sought not to collude with a sloppiness in policy commentary[1] that continues to equate 'national' with 'English', without asking the question 'which nation are we talking about here?'

**'Safeguarding adults'** and **'adult protection'** are used synonymously. The former term derived from the eponymous ADSS (2006) publication; its use has gained currency in England. 'Adult protection' has been used more in Wales; for this reason it is used here.

**'The Authority'** (capitalised) refers to the case, which was a social services department.

**'Lipsky'** refers to Michael Lipsky, and his thesis of street level bureaucracy presented in his 1980 book, *Street-Level Bureaucracy. Dilemmas of the individual in public services*. I have avoided over-referencing this to ease textual reading.

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[1] For example, the policy commentary in chapter one of the first UK prevalence study of elder abuse, published in 2007 some eight years after devolution, failed to differentiate policies of the four UK countries (O'Keeffe *et al:* 2007)

**Gendered pronouns**: I have preferred the androgynous 'they' to 'she' or 'he' when referring to individual respondents and others they may have referred to, in order to protect the anonymity of sources and service users. This was a small authority in a small country, with limited staff numbers and low numbers of adult protection referrals concerning older people. Removing the gender of the respondent as far as possible was a further protection of their anonymity. If this ran the risk of being ambiguous, confusing or clumsy, I reconstructed sentences and phrases in another way. This may have made some syntax clunky but the intention was, as far as possible, to strip out unnecessary identifiers, even if this made some prose less than polished.

**Respondent descriptors**: For the same reason, rather than referring to the job of the respondent, I have used three category descriptors: *Authority manager* (indicating policy making managers which were service managers, head of service, chair of the Area Adult Protection Committee (AAPC) and the adult protection coordinator); *social worker* (describing both senior practitioners and social workers); and *team manager*. Again, because numbers were small, to have disaggregated descriptors further would have identified specific people as often there was only one person occupying one described role.

# Chapter 2 Conceptualising the study

This chapter develops the conceptual framework for the study, and is in three parts. The first discusses four of Lipsky's key propositions about street level bureaucracy. The second section considers the UK policy context for statutory social work since the 1970s. The final section discusses concepts of discretion and power.

## *Lipsky and street level bureaucracy*

Lipsky's (1980) key thesis was this — in important ways policy was made through the day-to-day decisions, devices and routines street level workers established to cope with work pressures and uncertainties. He developed a series of propositions about the *processes* involved in this, four of which are considered here.

Firstly, Lipsky suggested street level bureaucrats made policy in two ways – through the individual acts of discretion they exercised, and then by the aggregation of those individual acts which became, *de facto*, the policy operated at the street level. This discretion was shaped by, for example, the degree of freedom in decision-making permitted by the agency and, conversely, the need to make decisions when agency policy was vague, ambiguous or non-existent. Lipsky suggested the exercise of discretion by street level bureaucrats could not be eliminated because of the nature and complexity of human service work. He dismissed the possibility of removing individual judgement as "we are not prepared as a society to abandon decisions about people and discretionary intervention to machines and programmed formats" (Lipsky 1980:xv). Further, Lipsky argued that the greater the discretion exercised, the greater the salience of his analysis (Lipsky 1980:15). Street level bureaucrats control the flow of information upwards to managers — itself an act of discretion. To maintain delivery of a service, in situations of uncertainty (where clear-cut solutions and actions were not possible), and at times of scarcity (when resources were stretched or non-existent), managers relied on the goodwill of street level bureaucrats to deliver the service.

Secondly, street level bureaucrats experienced dissonance as they struggled with dilemmas inherent in the structure of their work. Such dissonance and dilemmas represent the nexus of Lipsky's thesis (the sub-title of his 1980 book is "dilemmas of the individual in public services"), and their locus lay, he argued, in the structure of

street level bureaucrats' work and "a corrupted world of service" (Lipsky 1980:xiii). People come into public sector work with some commitment to service, "yet the very nature of this work prevents them from coming even close to the ideal conception of their jobs" (Lipsky 1980:xii). These aspirations were defeated by large caseloads, inadequate resources, and ambiguous, conflicting or vague agency policy. Instead, workers experienced the "myth of altruism" (Lipsky 1980:71) where agencies devote energy "to concealing lack of service and generating appearances of responsiveness" (Lipsky 1980:76).

To manage this dissonance and these dilemmas, Lipsky argued that street level bureaucrats adopted various coping strategies. They may protect themselves with "cognitive shields" that serve to blame or judge clients for their predicament, and protect the street level bureaucrat from responsibility to act (Lipsky 1980:153). Some employees drop out or burn out; others develop work practices that reflect lower expectations of themselves, clients, and the aspirations of public policy. Workers rationalise these compromises and practices as a reflection of their greater maturity, their appreciation of the realities of work and of what they can achieve. Such dissonance is compounded by workers having professional and bureaucratic status, both of which require compliance with rules. Some of these rules may be contradictory. Professionals may operate them selectively or in accord with the "norms and practices of their occupational group" (Lipsky 1980:14), which may be contrary to the bureaucratic rules.

Thirdly, Lipsky contended that the greater the dissonance experienced by street level bureaucrats, the more critical the workplace and its culture become in maintaining morale and reducing stress. Local routines, group norms and 'stories', and peer survival strategies assume greater significance in directing and controlling worker behaviour than policies, set procedures or the requirements of managers.

Lastly, Lipsky maintained the relationship between managers and street level bureaucrats was both conflictual **and** reciprocal (Lipsky 1980:25). Street level bureaucrats mostly work free of direct scrutiny by managers. They may exercise autonomy by having different priorities from their managers, by not accepting rules and by resisting control of their discretion. They may want to maximise their autonomy and process work in ways consistent with their own preferences, and only those policies backed up by significant sanctions. Managers, on the other hand, want

to minimise autonomy and achieve results consistent with objectives. They are concerned with performance, the costs of securing performance, "and only those aspects of process that expose them to critical scrutiny" (Lipsky 1980:19). Informal work processing strategies may be tacitly accepted by managers in order to protect the organisation from overload, even though they are contrary to agency policy. The resistance of street level bureaucrats is possible, Lipsky maintained, because their professional skills are required and it is hard to discipline or sack them. In short, Lipsky argued managers and organisations *need* street level bureaucrats to deliver the service.

Satyamurti's (1981) UK study of social work in a local authority at the time of the Seebohm reforms made no reference to Lipsky, but nonetheless illustrated some of Lipsky's arguments about public agencies. Satyamurti found the dilemmas social workers and their supervisors faced turned, partly, on their perception of the contradictory 'care' and 'control' aspects of their role. 'Management' of these dilemmas involved social workers categorising families and clients, evading administrative tasks and recording, being unavailable to clients, taking sick leave – all shades of Lipsky's 'cognitive shields'. Collectively, strategies involved blaming 'management', other agencies, resource shortfalls, or their own exclusion from policy making, which they did not attempt to influence. A strong team culture, where 'stories' of clients, managers, agencies were told and retold in frequent team meetings, meant deviation from group norms was not sanctioned. This bore striking resemblance to Lipsky's proposition that the greater the dissonance experienced by street level bureaucrats, the greater the influence of their immediate workplace colleagues and culture.

Writing in 1989, Hudson noted then the neglect of Lipsky, whose analysis of welfare bureaucracies Hudson regarded as having equivalence with Goffman's insights on total institutions – "(i)f we wish to study policy implementation, we must understand the street level bureaucrat" (Hudson 1997:402). Hudson suggested Lipsky's phenomenological focus on dilemmas was illuminating but needed development, as it paid insufficient attention to power and the interaction of its micro and macro manifestations.

Subsequently, Lipsky has enjoyed intermittent academic attention (eg, Ellis, Davis and Rummery 1999; Evans and Harris 2004). Baldwin (2000), for example,

suggested there was an in-built tension between the rationalist, top down policy tenets of community care and care management (with its implied *objectivity*), and the reality of assessment of need and care planning, which he argued required discretion (with its implied *subjectivity)*. Baldwin's interviews with care managers and managers in two English authorities found many examples of resistance to procedures by social workers: "(c)are managers have the scope to resist policy intentions and on the basis of this evidence they are doing so successfully" (Baldwin 2000:44). He remarked on the "venom" social workers and their managers directed towards community care forms and procedures but, when challenged, they could not substantiate this beyond "prejudice" (Baldwin 2000: 48). Baldwin's findings supported Lipsky's contention that street level bureaucrats modified client demand where resources are scarce: care managers tailored assessments to resources, and no unmet need was recorded (despite this being a core design feature of assessment and care management). Baldwin also found the use of discretion distorted policy intentions, as different workers interpreted guidance differently.

Ellis (2007) in her study of the implementation of direct payments policy in one English local authority concluded that after ten years of managerialism and the routinisation and regulation of social work, Lipsky remained useful in analysing frontline behaviour and interpretation of policy. Ellis identified tension for social workers in promoting direct payments between a legal obligation to ration services and the ethical obligation (underscored by the Code of Practice for social care workers) to promote self determination and empowerment. She found social workers did not promote direct payments because of the paperwork. Social workers had a number of "justificatory discourses" to legitimate their practice, for example direct payments take too long to discuss; service users were stereotyped *pace* Lipsky into those deserving and undeserving of assistance (Ellis 2007:411). Ellis concluded that a number of factors Lipsky wrote about remained relevant: demand exceeds supply of resources, objectives are indeterminate, and control of frontline discretion is limited.

Lipsky was writing about state programmes in the US in the 1970s, at a time when public programmes and federal investment to tackle economic, social and educational disadvantage had been scaled back drastically following earlier investment in the War on Poverty. The relevance of his concept to the street level

implementation of elder abuse must be viewed in the context of contemporary UK public policy, to which we now turn.

## *The changing face of social work in the UK*

The word 'crisis' dominated discourse on the UK welfare state in the latter part of the twentieth century. While the origins of that crisis and its challenges remain contested (Powell and Hewitt 2002), the UK government response included the introduction of market mechanisms, attempts to curb expenditure, and resource targeting. Within the personal social services, changes were dramatic. This section considers the nature and impact of these on the social work role.

The new right attack on the welfare state, led by successive Conservative governments between 1979 and 1997, was directed at large welfare bureaucracies said to be permeated by professional arrogance and bureaucratic inertia, and characterised as inefficient, incompetent and insensitive to consumer needs (Clarke and Newman 1993). The title of the Audit Commission's guide on these changes for social services — 'The Community Revolution' —made clear the scale of the challenges the Commission foresaw, where notions of 'empowerment' and 'choice' were regarded as central to the challenge to vested professional interests (Audit Commission 1992).

In adult personal social services major structural changes, presaged by the White Paper *Caring for People* (DH 1989), were introduced by the NHS and Community Care Act 1990 (NHSCC Act), described five years after its implementation as "the most influential piece of social policy legislation to affect the lives of older people in the 1990s" (Bernard and Phillips 1998:10). The social work role was restyled from provider to that of enabler, commissioner and service planner. Marketisation transformed social services departments from monopoly providers to an expanded role as commissioners of services, from a much larger independent sector. Managerialisation[2] created the 'new public management' whose *leitmotifs* were accountability, efficiency and competition (Pollitt, Birchall and Putman 1998).

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[2] Managerialisation has been defined as "the process of subjecting the control of public services to the principles, powers and practices of managerial co-ordination" (Clarke, Gewirtz and McLaughlin 2000:5)

This 'ideology of management' as Pollitt (1993) described it, maintained its hegemonic hold following the 1997 election of new Labour, albeit with certain themes amplified. 'Modernisation' and 'modernised management' were presented as the means to match public services to public expectations (DH 1998). Standards, performance indicators, monitoring, inspection and audit were mechanisms of choice to deliver this (Clarke *et al* 2000; Langan 2000). In social care, the Care Standards Act 2000 introduced workforce regulation, as well as the regulation of services required to be registered with the relevant inspectorate. Power (1997) likened this to transformation into a *regulatory* state; a process Munro (2004) argued was both destructive and simplistic for social work.

Whether increased marketisation and audit are sufficient to safeguard standards is both uncertain and contested. Commenting on the impacts of marketisation and regulation, Gary FitzGerald[3] in evidence to the parliamentary Joint Committee on Human Rights (JCHR), observed that "what we have seen is a very effective social market in driving down cost but not a terribly effective one in driving up standards" (JCHR 2007b: Q218). In social work, Preston-Shoot (2001) argued that the requirements of audit or procedures may introduce rigidity, and impose standardisation where interactions and interpretations are uncertain, confused or conjectural. In adult protection for example, national guidance in both England and Wales requires those using the policies to attend to protection and risk management, *and* to empower the vulnerable adult (DH 2000; NAfW 2000). *How* this balance of decision-making was to be achieved when dealing with alleged abuse is not a process readily standardised.

In broad terms, the social work profession had three enduring criticisms of these changes: first, the role of the social worker changed (for the worse); second, managerial control over social workers increased, to the detriment of autonomous professional decision-making; and thus thirdly, the scope for exercising professional discretion diminished.

Firstly, some argued that the changed role from social worker to care manager increased the control and policing aspects of the social work role (see La Valle and

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[3] Chief Executive of the charity Action on Elder Abuse.

Lyons 1996; Postle 2002). However, some historical perspective is needed. In 1979, Satyamurti described social workers reporting role conflict between care and control aspects of their work following introduction of the Seebohm reforms. She suggested this contradiction was intrinsic to a profession whose origins lay in the control functions of the Poor Law, and arose not simply as a result of contemporary structural change (Satyamurti 1979). In adult protection, it is the writer's experience that some social workers are concerned that the statutory powers they have to intervene in potentially abusive situations are insufficient. In Scotland, the Adult Support and Protection (Scotland) Act 2007 originated from an enquiry into the systematic and long term abuse of some people with learning disabilities (SWSI 2004). This Scottish legislation gives powers to council officers to enter places where adults are known or believed to be at risk of harm. In England, the Association of Directors of Social Services' position statement *Safeguarding Adults* (ADSS 2006) has been adopted by the English Association of Directors of Adult Social Services (ADASS) as its call for legislation and, at early 2009, the Department of Health is consulting on the need for adult protection legislation (DH 2008).

Secondly, structured assessment and care management processes have been criticised for emphasising managerial interests, and for shifting the balance of power to managers at the expense of social workers' professional autonomy (Lymbery 1998). Again, this criticism is not new. Hugman (1991) found managerialism apparent in the 1970s after the introduction of the changes following the implementation of the Seebohm Report (1968). Then as now, managers were mostly professional social workers, not generic managers (Exworthy and Halford 1999). These 'managerial professionals' built their careers from within their professional ranks; they were not managers 'imposed' on professionals from other sectors (Causer and Exworthy 1999).

Thirdly, these changes were criticised because of the supposed reduction in scope for exercising professional discretion. Post-Seebohm, social workers were considered to exercise high levels of professional discretion. As the exercise of discretion and the resulting power street level bureaucrats are said to possess lie at the heart of Lipsky's account of street level bureaucracy, the following section discusses theoretical concepts of power and discretion in turn.

## *Power and discretion*

The professional exercise of discretion imputes the existence of power, which is a primary sociological – and highly contested – concept. Lukes (1974), for example, doubted that issues in political and academic debate about power could ever be resolved empirically as important moral and political value issues were involved, and because "how much power you see in the social world and where you locate it depends how you conceive of it" (Lukes 2005:12).

### Theorising power

Lukes' core contention in the first edition of his short, but highly influential, book *Power: a radical view* (1974) was that power should be considered in three dimensions not two. Bachrach and Baratz (1970) had earlier named two dimensions, or 'faces' of power. The first dimension related to the debate about whether power was exercised by a narrow power elite (eg, Mills 1956) or by plural elites emanating from participatory democratic means (eg, Dahl 1961). Bachrach and Baratz proposed a 'second dimension' of power, that of decisionless decision-making, where (unwitting or deliberate) non-decisions resulted "in suppression or thwarting of a latent or manifest challenge to the values or interests of the decision-maker (Bachrach and Baratz 1970:44). For Lukes, a third dimension of power existed:

> the power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things.
>
> *(Lukes 2005:11)*

Lukes revised his thinking in his 2005 volume, particularly developing ideas presented in the second edition of Morriss' (2002) book, *Power. A philosophical Analysis*. Morriss had coined the terms 'vehicle' and 'exercise' fallacies, differentiating *the power to do something*, and *the doing of it*. Drawing on Morriss, Lukes contended power was a capacity that existed *whether or not it was exercised*. It was real and effective, sometimes in hidden ways; it may advance the interests of others whether or not a person 'consented'. Power was not delineated by what occurred when it was activated, as "power is a capacity, not the exercise or the vehicle of that capacity" (Lukes 2005:70). Whether or not this was willing or unwilling compliance Lukes regarded as simplistic, as power could be both

consented to *and* resented and was "at its most effective when least observable" (Lukes 2005:1).

Secondly, Lukes revised his earlier view that power was asymmetric: power was exercised *over* others, domination occurred between binary relations with unitary interests. Instead, Lukes' revised position was that power should be viewed as operating *amongst* many actors with multiple and conflicting interests, where power represented the imposition of internal constraints that those subject to power began to see as natural. Power as 'domination' was just one "species" of power, as a person could have power by advancing the interests of others (Lukes 2005:12). Together, Lukes contended these mechanisms operated to produce the third dimension of power. To understand when this was at work, and to understand how domination works, the search must be for the hidden, least visible, signs of power (Lukes 2005). Suggesting that power is a 'dispositional' concept (a capacity which may or may not be exercised) "comprising a conjunction of conditional or hypothetical statements specifying what would occur under a range of circumstances if and when power is exercised", Lukes argued that power is most effective when it is least accessible to observation (Lukes 2005:63). Perceived thus, the professional power of social workers is inextricably connected to the discretion they have in their decision-making. This is considered next, concluding this chapter.

## Theorising discretion

Whether or not social work discretion has been curtailed or continues has, as we have seen, been a repetitive theme in the social work profession for some time. What though, as Dworkin (1978) asked, does saying someone 'has discretion' mean? Dworkin answered his question thus:

> (when someone) ... is in general charged with making decisions subject to standards set by a particular authority ... Discretion, like the hole in the doughnut, does not exist except as an area left open by a surrounding belt of restriction.
>
> *(Dworkin 1978:31)*

Dworkin viewed discretion as a relative concept (as did Lipsky) whose meaning was affected by context. His definition required addressing two questions "discretion under which standards? ... as to which authority?" (*ibid*). He suggested two ways to consider discretion. In the first, weak discretion pertained where standards could not

apply mechanically but needed some judgement, or where an official had final authority that could not be revised by another. The second, strong discretion, existed where judgment was needed to apply standards, where no one reviewed that exercise of judgement, or where an official was not bound by the standards in question. Strong discretion was not a licence to act at will, nor did it exclude the possibility of criticism of the judgement reached. Neither did it mean an official exercised judgement outside standards of fairness and sense, but only that the decision was not controlled by standards. Hence, returning to his definition, Dworkin said such a decision, reached through the exercise of strong discretion, still lay within the doughnut's perimeter.

The long-running debate in statutory social work about the continuation or curtailment of discretion has not been over-informed by empirical evidence nor, with some exceptions[4], by Lipsky's work on street level bureaucracy. Arguing that discretion had been curtailed, Howe, for example, maintained that much social work practice was determined and constructed within a welfare bureaucracy, where managers required predictable work environments and workflow, and sought to reduce social work discretion. With a nod to Lipsky, Howe (1991:219) conceded that "pockets of freedom" may exist because some work could not be routinised as it required judgement. Lymbery, too, argued social work discretion was curtailed by the NHSCC Act 1990. Increased managerial control of social workers had, he suggested, "potentially serious" consequences for social work with older people (Lymbery 1998: 2001). Lymbery maintained social work's location within hierarchical accountability frameworks (that include structured procedural processes and standards) reduced the autonomy of an individual worker. Lymbery (1998) contended assessment and care management processes had resulted in a diminution in the amount of counselling social workers undertook (because time and resources were restricted), and an increase in care planning, which Lymbery seemed to regard as a technocratic administrative task, devoid of professional judgement.

In fact, little empirical evidence is available on the amount of time social workers spent on counselling before or after the introduction of care management. In any

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[4] For example Baldwin (2000) and Evans and Harris (2004).

case, its introduction did not preclude social workers providing counselling or any other 'social work' service — "social work ... is a provision in its own right, to be commissioned by the care manager ..." (Audit Commission 1992:27). Weinberg *et al*'s (2003) study of how time was used by social work teams in one English local authority found the amount of care manager time spent in face-to-face contact with service users was little changed from that reported prior to the Seebohm reforms of the early 1970s. Further, as Evans and Harris (2004) noted, Lymbery assumed managers could control workers' behaviour in ways that limited their discretion and autonomy. In reality, managers may be ignorant of day-to-day practice and policies and, as much social work practice is done away from managerial view, local team cultures (or "the way things are done here") mean professional autonomy is exercised in their implementation (Preston-Shoot 2001:9). Salman's (2007) interviews with British social workers illustrated ways in which practitioners were 'playing the game', for example: "you bend rules by talking up clients' needs, in order to help them; it's called the rationing game" (a former social services director); or, "I need to bend the rules because my employer has raised the barrier to eligible needs" (social worker with older people).

Other empirical work indicated professional discretion remained a feature of decision-making, although social workers perceived otherwise. Ellis, Davis and Rummery (1999) reviewed how far 'bottom-up' decision-making by social workers had been controlled by the care management changes of the 1990s. In their research with six social work teams, the discrete steps of assessment and care management were "experienced as an assault on professional identity" (Ellis, Davis and Rummery 1999:274), and seen as a threat to good practice. The researchers found however that the team with the heaviest referral rates was driven by assessment and eligibility criteria and, despite their claim to provide needs-led assessments, this hospital team focused on the provision of personal care, that is, a *service*-led response. The authors concluded that professional discretion had been used defensively in the past to ration services and social workers' professional autonomy then had been "something of a myth" (Ellis, Davis and Rummery 1999:277). They identified similarities with the circumstances (scarcity and uncertainty) Lipsky had described:

> In some limited respects, community care reforms recreate the conditions under which street level bureaucracy flourished in social services departments in the 1970s

> and 1980s, when frontline staff had ultimate responsibility for managing inflated and conflictual policy objectives with inadequate levels of resources relative to demand, yet were subject to low managerial activity.
>
> *(Ellis, Davis and Rummery 1999:276).*

Evans and Harris (2004) acknowledged the importance of Lipsky's work to what they called the curtailment and continuation strands of debates about social work discretion. They argued that increased rules and regulations do not automatically result in greater control as more rules may create more discretion. Further, discretion was neither inherently bad or good. Sometimes it may be important, other times it may be a cloak for professionals to hide behind, or an opportunity for abuse of power. Discretion was not simply present or absent in decision-making: the existence of discretion was not the absence of rules. Using Dworkin's doughnut, the standards are the doughnut, the discretion the hole. Judgement has to be exercised in relation to a standard, to a procedure, to legislation and regulation applying to a particular circumstance. Strong professional discretion was still subject to tests of fairness, reasonableness. Weaker discretion must operate in situations where rules may be ambiguous, conflicting, vague. Professionals must decide which rule operates in which situation at which time (Evans and Harris 2004).

In fact, it is often *guidance* that is demanded by social workers operating in a complex and sometimes contradictory policy framework, for example, promoting user-led services, safeguarding and cost containment. At different points in a process one or other of these can be emphasised by the exercise of discretion. Evans and Harris asked, somewhat rhetorically, "(w)ho... decides when the point has been reached at which the circumstances require a shift from the practitioner's discretionary judgement to falling within the procedures?". As professionals make this judgement they concluded "... by creating rules, organizations create discretion" (Evans and Harris 2004:883).

Finally, of course, rules and procedures do not protect elders from abuse, nor do they *ipso facto* improve professional practice; as Stevenson commented "procedures are a necessary but not a sufficient condition for the development of good practice" (Stevenson 1996, cited in Slater, 2002:445). Procedures may exist, but not be read, used or understood. The existence of procedures, guidance and training does not resolve the tension between proceduralisation and the exercise of professional

discretion. Even if 'good' procedures and training could first of all be developed and, secondly, protect elders from abuse – a patent absurdity – dilemmas remain for the street level bureaucrat in their exercise of judgment and discretion to protect a vulnerable elder.

This chapter has laid the conceptual map for this research. It has considered elements of Lipsky's thesis of street level bureaucracy, reviewed changes in the policy backcloth of UK social work, and considered concepts of power and discretion. Chapter 3 reviews key literature on elder abuse policy and research, and discusses the concept of ageism.

# Chapter 3 Elder abuse: policy, research and ageism

This chapter reviews key literature on elder abuse and is in four parts. The first outlines recent history of identifying ('naming') and researching elder abuse in the UK. The second section leads from this, and considers issues of definition and prevalence of elder abuse. Thirdly, 'thresholds' of abuse are discussed, that is, whether or not acts (of omission or commission) are deemed potentially abusive by those charged with policy implementation. Finally, the concept of ageism and its manifestations in realising the human rights of elders are considered.

## *'Naming' and researching elder abuse in the UK*

Blumer (1971) advised us that social problems, far from being an objective 'fact', become named as such through a process of collective definition. If that is so, then that collective defining process took shape in the 1990s, when policy and professional concerns coalesced to result in the social policy 'naming' of elder abuse in the UK (McCreadie 1996). Whilst Brammer and Biggs suggested that "the British experience shows a relative absence of concern" (1998:285) and, certainly, media outrage and social opprobrium about, say, the death of older people due to abuse or neglect have not been sustained focal features of public discourse, disparate concerns about the treatment of older people have been raised in UK literature since the 1970s. The first attributed UK reference to what he called "granny battering" was by Baker (1975, cited in Richardson, Kitchen and Livingston, 2002:340); a term Eastman, then a social worker, used in various articles published in the early 1980s (eg, Eastman 1982). In 1988, the British Geriatrics Society convened the first UK conference on the abuse of older people (BGS 2005). This was attended by 400 professionals including those from the British Association of Social Workers, Carers National Association and Age Concern. Following this, the document *Abuse of Elderly People*: *guidelines for action for those working with elderly people* was published, to assist staff identify older people who may be abused, or at risk, in domestic situations (Decalmer and Glendinning 1993).

In 1990 the Department of Health commissioned the Age Concern Institute of Gerontology to produce what was to be the first UK scoping study. This "exploratory study" described the "stirrings at the grass roots" about elder abuse, and identified key players (just twelve) involved in this work in England and Wales (McCreadie

1991:2, 15). These were professionals working in medicine, health and social work, and it was largely professionals, or what Estes (1979, cited in Brogden and Nijhar, 2000) called the 'aging enterprises', who drove the issue of elder abuse onto policy-makers' agendas (Slater 2002). McCreadie's (1991) study reported a lack of guidelines, policies and procedures in the area; her report's six page reference list identified the main UK and US published research — the latter far exceeded the former.

When she updated her report five years later, McCreadie described the development of interest in elder abuse as having been an "explosion" (McCreadie 1996:1), such had been the increase in research (albeit mostly small-scale studies) and professional interest in the topic. Professional concern at this time was largely focused on the treatment of older people, and on stress experienced by carers of older people, particularly those with dementia. The Social Services Inspectorate (1992) had published *Confronting Elder Abuse* which drew attention to the absence of policies and guidance for social workers in two London boroughs. This was followed by the publication of *No Longer Afraid* on safeguarding older people in domestic settings (SSI 1993). Overall however, the development of local policies within the UK at this time was ad hoc, and no national policy guidance was published in either England or Wales until 2000. This policy context is considered later in this chapter; for now this section turns to consider research perspectives on elder abuse.

## Research perspectives on elder abuse

The bulk of available research on elder abuse has been done in North America, hence research perspectives emphasise the interests and approaches of US and Canadian academics, notably a focus on psychodynamic, individualistic understandings of abuse (for example, Lachs and Pillemer 2004; Mellor and Brownell 2006). Apart from a plethora of small scale, qualitative studies, research attention in the UK has not been extensive compared to, say, domestic violence or hate crimes generally. In their systematic literature review, Manthorpe *et al* (2004) commented on the dearth of reliable research and findings on elder abuse in the UK. Gaps included a lack of research on links between elder abuse and domestic violence, despite — as Homer and Gilleard (1990:1391) had noted some 15 years before — victims possibly being "elderly graduates of domestic violence", or as Straka and Montminy (2006:251)

describe it, "domestic violence grown old".

Brogden and Nijhar (2000) suggested the research focus on the individual pathology (of perpetrators) and individual vulnerability (of the abused), represented one of two approaches to understanding and responding to elder abuse, that is, a 'welfarist' perspective. This is in contrast with the second 'justice' approach, which views elder abuse through a lens that emphasises the rights of elders, as citizens, to criminal justice. UK research output, like its North American counterpart, has largely reflected a welfarist, rather than criminal justice understanding of the lives of older people as potential victims of abuse (Brammer and Biggs 1998). This welfare, or 'treatment' approach by doctors and the like to understanding elder abuse, drew heavily on child abuse research, and focused largely on family dynamics and dysfunction, inter-personal relationships and individual pathology (for example, Wolf and Pillemer 1989; Mellor and Brownell 2006). Brogden and Nijhar (2000:18) argued this fell into the "welfarist trap", mistakenly analogising frail elders with abused children, and ghettoising elder abuse as a 'welfare', not 'justice' concern. In any case, elder abuse research has been, and remains, beset with problems of definition about what acts or actions and perpetrated by whom, constitute abuse. This debate, and the prevalence of elder abuse, are considered next.

## *Definition and prevalence*

The term 'elder abuse' has no legal definition in England and Wales (CPS 2008). What constitutes elder abuse has been defined in different ways, a situation described by Pillemer and Finkelhor (1988:52) in the late 1980s as "definitional disarray", and by others as the "vain search for definitions" (Brogden and Nijhar 2000:40). Policy guidance in England and Wales has not differentiated elder abuse from abuse of other vulnerable adults. Elder abuse is located within a policy framework of protection for all vulnerable adults, where a vulnerable adult is defined as a "person aged 18 years or over who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation". Abuse is defined as "a violation of an individual's human and civil rights by any other person or persons", and policy guidance refers to five categories of abuse: physical, sexual, psychological, financial and neglect (DH 2000:8-9; NAfW 2000:14).

Somewhat differently, the World Health Organisation (WHO) and the charity Action on Elder Abuse (AEA), have defined elder abuse as a "single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (AEA 2007b; WHO: 2002a). This definition emphasises a relationship and an abuse of *trust*. The definition used in policy in England and Wales is wider, both in its attention to all those defined as 'vulnerable adults', and its lack of reference to the nature of the relationship between abused and abuser. In their review of elder abuse research gaps, Manthorpe *et al* (2004) concluded that consensus was needed about a standardised definition of elder abuse that reflected both elders' perceptions and the legal framework.

Whilst definitions and categorisation of 'abuse / not abuse' can be diversionary or distracting in terms of promoting the citizenship rights of elders (Wilson 2004), they are important in the context of this research. Firstly, *words* can be powerful signifiers of how acts of commission or omission are interpreted by street level bureaucrats (and adult protection systems) and hence the response made to the older person. 'Financial abuse' for example, is not a term used to describe crimes like stealing, theft or fraud committed against anyone who has not been labelled a 'vulnerable adult'. 'Physical abuse' is assault or grievous bodily harm, depending on the act, severity or circumstances. To use Bourdieu's (1977) concept, the 'euphemisation' of the term 'abuse' and its appended epithets, softens and sanitises, opening the way to welfarist rather than criminal responses to acts which, if committed against anyone else, would be labelled a crime (Williams 1993).

Secondly, finding out how local implementation of adult protection procedures might be shaped by street level bureaucrats requires exploration of the workers' naming of situations, circumstances and behaviours they recognise as potential 'abuse' under their procedures, that is, which cross an intervention threshold. Policy definitions clearly frame that 'naming' process, as they do the nature of inter-organisational arrangement, and type and volume of resource that determines a response, whether welfare or legal. They also affect what is deemed abuse, or not, in prevalence research, and it is this I discuss next.

## Prevalence of elder abuse in the UK

The first UK prevalence survey of the abuse and neglect of older people was published in 2007 (O'Keeffe *et al* 2007)[5]. The 2007 study surveyed 2100 people aged 66 and over living in private households across the four UK countries. The aim was to provide prevalence estimates for each country as well as the UK as a whole. People with dementia were excluded (there were no proxy interviews), as were people living in care homes. Abuse by strangers was not surveyed.

Three definitions of abuse were used in this research. 'Mistreatment' (a term favoured by US researchers), described neglect, physical, sexual, financial and psychological abuse (the five abuse categories used in national policy guidance in Wales). 'Abuse' in the prevalence report referred to all categories *except neglect*. The third term used, 'interpersonal abuse', (again a term common in the North American abuse literature), referred *only* to physical, sexual and psychological abuse (O'Keefe *et al* 2007).

In comments that follow, I have eschewed this threefold spread as an unnecessarily complicated refuelling of the 'definitional disarray' that the adviser to the survey, Karl Pillemer, had remarked upon some twenty years previously. Instead, I use the terms found in national policy guidance (NAfW 2000), and refer to the type of abuse ('physical abuse', 'psychological abuse', as appropriate), or use the generic umbrella term 'abuse' to refer to the five categories (physical, psychological, sexual and financial abuse, and neglect).

As well as three definitions of abuse, the prevalence survey also differentiated rates of abuse by different groups of perpetrators. The abuse rate of 2.6 per cent was identified in relationships where there was "an *expectation* of trust, namely family, friends and care workers" (O'Keeffe *et al* 2007: 17. Emphasis added). This equated to around 227,000 older people reporting abuse by family, friend or care worker in the previous year. The next paragraph of the survey report continued: "(h)owever, the survey also covers mistreatment by neighbours and acquaintances as well as by

---

[5] Prior to this, Ogg and Bennett's (1992) prevalence research was generally cited: this had projected a figure of up to five per cent of people aged 65 and over had experienced verbal abuse; up to two per cent experienced physical or financial abuse.

those in a "*position* of trust" (*Ibid.* Emphasis added). When neighbours and acquaintances were included, the reported rate of abuse within the previous year was four per cent (equating to 342,400 people).

The conflation of '*expectation* of trust' with '*position* of trust' without explanatory text within four lines of the survey was unexplained. Similarly, any difference *from an older person's point of view* of abuse by a trusted neighbour providing informal care whom they may see several times a day, and a paid care worker doing intermittent shifts, was not clear; the more so as the report went on to comment on the difficulty of distinguishing care provided by 'friends' from 'acquaintances' or 'neighbours' (O'Keefe *et al* 2007:17). Qualitative findings from survey interviews with 36 older people contacted as a linked part of the UK prevalence survey acknowledged the difficulties presented in using researchers' definitions rather than older people's experiences of abuse. The authors of this qualitative report concluded that the definitions of elder mistreatment used, and the definitions of perpetrators, lacked clarity for the older people they interviewed (Mowlam *et al* 2007:iii). It is reasonable to assume that this lack of clarity affected rates of reporting. I return to potential underreporting of abuse in this survey later in this chapter.

In terms of its findings, the prevalence survey found neglect[6] was the most common form of abuse reported in the UK. Women were more much more likely (5.4 per cent) to report abuse within the previous year than men (2.1 per cent). Reported prevalence increased with declining health: people saying their health was poor, or that they had a limiting long-term illness, lower quality of life or depression reported higher levels of abuse, as did those saying they had felt lonely in the last week. There was a trend for abuse[7] to increase with age, and the risk factors for elder abuse were: living alone; receiving services; bad health; being an older woman; and being a woman who was divorced, separated or lonely (O'Keefe *et al* 2007).

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[6] Neglect was defined as ten or more instances (or less if judged by the respondent to be very serious) of failure to receive help required with day-to-day activities, personal care, getting the correct dose and timing of medication.

[7] That is, the five abuse categories used in *In Safe Hands*, the national policy guidance for Wales (NAfW:2000).

The prevalence of abuse by family, friends, care givers, neighbours and acquaintances across the nations is shown in Table 3.1.

**Table 3.1 Prevalence of abuse [a] by country and gender within previous year by family, friend, care giver [b], neighbour, acquaintance**

**(Broader perpetrator definition)**

| | England | Wales | Scotland | N. Ireland | **Total** |
|---|---|---|---|---|---|
| | % | % | % | % | % |
| **Men** | | | | | |
| Neglect | 0.6 | 1.6 | 2.1 | - | 0.8 |
| Financial | 0.6 | 1.5 | 1.9 | 1.2 | 0.8 |
| Interpersonal [c] | 0.4 | 2.7 | 1.1 | 1.2 | 0.6 |
| ***Any category of abuse*** | **1.6** | **5.8** | **5.2** | **2.4** | **2.1** |
| ***Any abuse excluding neglect*** | 1.0 | 4.1 | 3.0 | 2.4 | 1.3 |
| **Women** | | | | | |
| Neglect | 1.6 | 1.9 | 1.2 | 2.2 | 1.6 |
| Financial | 1.2 | 2.7 | - | 1.3 | 1.2 |
| Interpersonal [c] | 2.8 | 2.9 | 2.4 | 0.4 | 2.7 |
| ***All abuse categories*** | **5.6** | **6.2** | **3.6** | **3.4** | **5.4** |
| ***Any abuse excluding neglect*** | 4.0 | 5.3 | 2.4 | 1.7 | 3.9 |
| **All** | | | | | |
| Neglect | 1.1 | 1.8 | 1.6 | 1.3 | 1.2 |
| Financial | 0.9 | 2.2 | 0.8 | 1.3 | 1.0 |
| Interpersonal [c] | 1.7 | 2.8 | 1.8 | 0.7 | 1.8 |
| ***All abuse categories*** | **3.9** | **6.0** | **4.3** | **3.0** | **4.0** |
| ***Any abuse excluding neglect*** | 2.7 | 4.8 | 2.7 | 2.0 | 2.8 |

[a] Respondents could mention more than one abuse category (physical, sexual, psychological, financial, neglect).

[b] 'Care giver' was described as a health professional (doctor, nurse, health visitor), social worker, home care worker.

[c] Interpersonal abuse referred to physical, sexual and psychological abuse only.

**Source: Adapted from: O'Keeffe *et al* (2007:73).**

In terms of a breakdown of data across the four UK nations, less than one in ten of the data tables in the prevalence survey disaggregated data to each country and, at autumn 2008, none of the devolved governments or administrations had commissioned secondary analysis of their country data set. In Wales, 372 people

aged 66 and over took part in the survey, a response rate of 54 per cent[8]. The rate of abuse reported by family, friends, care workers neighbours and acquaintances was six per cent, the highest of the four countries. Slightly more women (6.2 per cent) than men (5.8 per cent) in Wales reported abuse (this was not statistically significant); across the UK, women (4.3 per cent) were almost twice as likely to report abuse than men (2.3 per cent). In Wales, women (2.7 per cent) were almost twice as likely than men (1.5 per cent) to report financial abuse, while abuse in the other categories (physical, psychological, sexual) were less marked between men and women.

**Domestic abuse**

What stands out from the Wales data are the rates for 'interpersonal' abuse, the umbrella term used in the survey for physical, psychological and sexual abuse. Taking men and women together, the rate in Wales was 2.8 per cent, compared to 1.7, 1.8 and 0.7 per cent rates for England, Scotland and Northern Ireland respectively. In reality however, physical, psychological and sexual abuse within the home are more typically understood as domestic abuse, as is seen from the definition in the Wales national strategy *Tackling Domestic Abuse*:

> Domestic abuse is best described as the use of physical and/or emotional abuse or violence, including undermining of self-confidence, sexual violence or the threat of violence, by a person who is or has been in a close relationship. Domestic abuse can go beyond actual physical violence. It can also involve emotional abuse, the destruction of a spouse's or partner's property, their isolation from friends, family or other potential sources of support, threats to others including children, control over access to money, personal; items, food, transportation and the telephone, and stalking.

*(WAG 2005:6).*

Taking 'interpersonal abuse' to mean domestic abuse then the UK survey data on this are stark, as shown in Table 3.2.

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[8] This was the lowest response rate of the four UK countries, where the average response rate was 67 per cent. However the sampling frame used in Wales differed from that used in England, Scotland and Ireland.

**Table 3.2 Relationship of perpetrator (including neighbours and acquaintances) to respondent, by type of abuse (four-country data)**

| Relationship of perpetrator | Type of abuse | | | | |
|---|---|---|---|---|---|
| | Neglect % | Financial % | Inter-personal abuse[a] % | Any abuse (excl. neglect) % | Any abu |
| Partner | 62 | 9 | 31 | 23 | |
| Other family | 51 | 35 | 20 | 25 | |
| Close friend | 3 | 1 | 4 | 3 | |
| Care worker | 13 | 20 | - | 7 | |
| Acquaintance or neighbour | 11 | 35 | 45 | 41 | |

[a] Physical, sexual and psychological abuse only.

**Source: Adapted from: O'Keeffe *et al* (2007:75).**

Partners or other family members were the main perpetrators of domestic abuse (51 per cent), but neighbours and acquaintances (45 per cent) were reported as perpetrators only slightly less often. The risk to women of being physically abused decreased with age: the rate for women aged 66-84 was 1.1 per cent, compared to 0.1 per cent for women aged 85 and over, indicating that widowhood decreased the risk of physical abuse for women (O'Keeffe *et al,* 2007:70; all four-country data).

### Disclosing abuse

These findings strongly indicate the levels of domestic abuse older people are experiencing *and* that they are reporting to others. This pattern of disclosure held with other types of abuse, ie, neglect and financial abuse. Somewhat unexpectedly, given a common assumption that older people would keep abuse to themselves, 70 per cent who reported abuse in the UK in the previous year had told someone like a family member or friend, a health professional or social worker. Only six per cent reported abuse to the police. It was estimated that just three per cent of reports of abuse by older people reached adult protection services (O'Keefe *et al* 2007). It is unfortunate that the researchers did not ask what happened after abuse was reported. Given the Department of Health were co-funders of this research, this appears a

strange omission, as a survey on this scale would have been a fine opportunity to capture this data[9], of obvious significance to those developing policy and services.

**Underreporting abuse?**

These prevalence figures are almost certainly an underestimate, which the survey report acknowledged. Firstly, people with dementia[10] or otherwise without mental capacity, were not surveyed. They are likely to be at higher risk of abuse (poor health was an identified risk factor). Secondly, and significantly, care home residents were not surveyed. The levels of abuse of people in care homes providing nursing care has continued to exercise the care and social services Chief Inspector in Wales, who commented in his 2006-2007 report that "it is of concern that 61% of adult protection investigations in care homes relate to homes with nursing care, particularly since these homes make up only 25% of the sector" (CSSIW 2008a:5). The number of adult protection referrals to the Wales social care regulator concerning care homes increased in 2006-07: less than two-thirds of care homes (63 per cent) met the requirement to review care plans regularly; almost one third of inspection reports (30 per cent) identified the need for improvement in the reviewing process (CSSIW 2008b:64). Given that individual care plans and regular reviews *involving the older person* are one means by which concerns can be raised, this suggested abuse is under-reported in Wales.

Thirdly, the way definitions of abuse used in the prevalence report were operationalised may have led to underreporting. To be counted as suffering

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[9] This seemed to be a point the researchers retrospectively acknowledged: "(w)e did not ask what the consequences of asking for help were ... it would be interesting to know how these practitioners responded...". McCreadie C, Biggs S, Hills A, Manthorpe J, Tinker A, Doyle M, O'Keefe M, Constantine R, Scholes S and Erens B *Who really knows about the mistreatment of older people?* Posted 26 March 2008 to http://www.communitycare.co.uk/Articles/Article.aspx?liArticleID=107725&PrinterFriendly=true. Accessed: 03 04 08.

[10] The Alzheimer's Society (2007) conservatively estimated there were 648,000 people with dementia in the UK, a number forecasted to rise to nearly one million by 2021.

psychological abuse[11], an elder had to have experienced *ten* or more instances by the *same* person in the past year. This meant, therefore, that eight or nine threats would not have 'counted' (in the unlikely event an elder kept a tally); neither would less than ten serious threats by several family members. A threat like 'we'll have this house off you', or 'I'll have this dog put down', or 'you'll have to go into a home' may only need to be made once, with venom, malice or force, to secure the silence, acquiescence or accommodation of an elder to action they neither consent to nor desire. Further, whilst the prevalence survey's manner of operationalisation may have been consistent with that used in an early US prevalence survey carried out twenty years earlier (Pillemer and Finkelhor 1988[12]), it does not reflect potential impact, seriousness or trauma on the elder, nor 21st century policy expectations of zero tolerance of domestic abuse.

Lastly, the headline abuse prevalence figures of 2.6 and 4 per cent referred to abuse *only* in the previous year. When people were asked about abuse[13] since the age of 65, rather than only in the previous year, the abuse prevalence rates were between 50 and 100 per cent higher depending on the types of abuse (O'Keefe *et al* 2007:68).

Certainly other international studies and data have identified higher rates of abuse than the UK prevalence study reported. In their systematic review of international studies measuring the prevalence of elder abuse or neglect, Cooper, Selwood and Livingston concluded that one in four older people were at risk of abuse, only a small proportion of which was currently detected. They also found, as the UK prevalence study did, that elders and families "are willing to report abuse and should be asked about it routinely" (Cooper, Selwood and Livingston (2008:151). Similarly, Ockleford *et al* (2003) reporting on interviews with an opportunity sample of 149

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[11] The operational definition of psychological abuse was ten or more instances of psychological abuse in the past year by the same person (family member, close friend, care worker): being insulted; threatening, undermining or belittling; excluding or repeatedly ignoring, threatening harm to the elder or others they care about; preventing the elder seeing someone they care about (O'Keeffe 2007:15).

[12] This research had asked about physical, psychological abuse and neglect; it did not concern itself with sexual or financial abuse of older people.

[13] Respondents were asked only about physical, sexual and financial abuse since the age of 65; neglect and psychological abuse were not considered.

older women in UK, Italy and the Republic of Ireland, found one quarter reported some form of mistreatment, mostly by spouses or other family members. Of these, 76 per cent (26) disclosed the abuse to someone; very few said they found this useful. Older women experiencing domestic abuse were simply not visible to professional and voluntary support services contacted[14]: no demographic data on age or gender of service users, or reasons for contacting the services, were recorded.

If some elders are reporting abuse, but these reports are not 'heard' or actioned as abuse referrals by professionals, this raises a question about the thresholds used by street level bureaucrats when judging an act abusive or not. The following, penultimate, section of this chapter considers this.

## *Abuse or not abuse: the notion of 'threshold'*

We know little as yet about what influences local reporting of abuse. Fundamental to the implementation of procedures, and to this research, is the *threshold* used by practitioners to judge whether a situation is one of potential abuse.

In their work on the implementation of adult protection procedures in two English counties, Brown and Stein (1998) attributed different levels of reporting between and within each county to differential awareness and practice by practitioners, as well as differences placed on the importance of procedures by local managers. Brown and Stein reported workers operated their own 'adjustable thresholds' of intervention. 'Informal' responses might involve additional support or monitoring without using adult protection procedures; a 'formal' response involved instigating procedures. Other work showed practitioners influenced by their own values and beliefs, as well as their training and experience[15].

The local operationalisation of 'thresholds' is, in the researcher's experience, a matter of much debate, both at the team and AAPC level. A number of factors potentially bear on whether a situation is named as an adult protection alert, including: the worker's awareness of abuse and willingness to report; the number of

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[14] Such services included the country (UK, ROI and Italy) equivalent of social services, Women's Aid, Citizens Advice, the police, counselling services, organisations like Alzheimer's Society and Age Concern.

[15] Personal communication, Claudine McCreadie, King's College, London, 8 August 2006.

times an action (or non-action) occurs; the amount of experience the social worker has; and the impact of ageism and social and cultural values on decision-making.

Firstly, conceptualising and operationalising a notion of 'threshold' depends on staff being aware of what abuse is. Using data from 150 statutory and voluntary sector respondents working to Surrey adult protection committee procedures, Taylor and Dodd (2003) found staff did not identify all forms of abuse, particularly neglect. One-third of respondents said they thought a local investigation would resolve issues without using adult protection procedures, and while training increased awareness, people were significantly more likely to try and deal with the alleged abuse themselves rather than through procedures. Overall, the authors commented "(t)he decision to report seemed to be based on a more subjective perspective, such as if it was 'severe enough' or repeated". (Taylor and Dodd 2003:31).

Some situations may be less than clear-cut for a social worker judging whether or not to use adult protection procedures. Is it potential abuse, for example, when an adult son regularly 'borrows' (without repaying) a chunk of his mother's pension? If the mother is dependent on that son for company and day-to-day help to stay in her home, is her son's appropriation of part of her pension more acceptable, and thus less (*sic*) abusive? How is the 'threshold' between 'abuse' and 'not abuse' (and the gradations between these) conceptualised by the social worker? The worker's interpretation of an elder's situation is likely to be key in *how* the situation is described to a team manager, or *whether* it is discussed at all. Might it, for example, be expedient for social workers to 'overlook' domestic situations which, if they collapsed, would present them with dilemmas about how best to support an elder with complex needs in a resource-starved service world?

Secondly, governments in England and Wales have defined abuse as a violation of an individual's human and civil rights by any other person or persons. National policy guidance in Wales uses the Law Commission's concept of 'significant harm' as an minimum threshold for intervention, described thus:

> (i)ll treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of, or an avoidable deterioration in physical or mental health; and the impairment of physical, emotional, social or behavioural development.
>
> *(NAfW:2000:16)*

The number of times an abusive act or action occurred is not a test of significant harm. However, in its analysis of phone calls to its helpline, the charity Action on Elder Abuse has reported many cases of financial abuse fail what AEA described as 'threshold tests' used by statutory agencies, where initial amounts of money taken from older people appear 'small' (*sic*), that is about £20-£30 per week. AEA cited examples of elders having insufficient food and living in increasing squalor, while the relatively small amounts stolen from them added up to many thousands of pounds (AEA 2007c). How widespread this practice might be is unknown, it does not derive from statutory guidance. If such a threshold is employed, it ignores the cumulative effect on an older person of losing, in the example above, around a fifth of the weekly state pension at 2007 rates.

A third variable potentially influencing how concerns about an elder are understood by a social worker relates to the amount of experience the worker has. Fook (2000) looked at differences between social workers with five or more years post-qualifying experience and those with less experience. She found those with greater experience recognised and engaged more with the complexity and the context of situations they encountered than less experienced workers. In terms of this present study, there may be differences between workers that relate to the amount and type of their experience of elder abuse, and their confidence and skills in probing and engaging with situations that may be less than clear-cut (as much abuse is).

Finally, ageism and ageist attitudes about older people, and about what is acceptable for elders but unacceptable for others, will influence how individual interpretations of thresholds are made (and where lines are drawn between the acceptable and unacceptable). These interpretations are made within a social and cultural context where the social status of elders may be diminished relative to other citizens. Conceptualising acts and activities as abuse, or not, is a very powerful exercise of professional discretion. Procedures may tell the social worker to raise an adult protection alert when they have suspicions of abuse; however if the elder's situation is not 'seen' as abuse but as a need to be care-managed, that exercise of discretion will fall under the adult protection radar.

## Abuse or not abuse: the notion of 'choice'

An adult's autonomy and right to make decisions poses a further dilemma for social workers. In their research of how adult protection procedures were used where elder abuse was suspected in domestic settings, Preston-Shoot and Wigley found

> (m)any practitioners then seemed to err on the side of doing nothing rather than taking action which may turn out to be unnecessary, especially if intervention was judged to risk destabilising the relationship they had established with a 'client'.
>
> *(Preston-Shoot and Wigley 2002:307)*

Preston-Shoot and Wigley suggested many staff privileged self-determination over protection. Considerable weight could be given to a person's views, described by social workers as their 'choice' — even when this left them exposed to risk[16]. Adult protection procedures were more likely to be used when something fell outside the experience of the worker, but for many there was confusion about the extent to which they could exercise discretion within the procedures.

Preston-Shoot and Wigley's (2002) study also raised questions relevant to this research, namely how far the exercise of 'choice', and self-determination' are possible if an elder is frail, dependent on their abuser for care, has suffered domestic violence for most of their adult life, or is living in impoverished, isolated circumstances. Choice is not an absolute concept, but is nuanced, contradictory and shaped by social and cultural factors that find expression in policy. It is those contradictions – or (after Lipsky) 'dilemmas' – that social workers face when judging whether or not to use the adult protection procedures.

Bergeron's (2006) US research illustrated these themes. Bergeron suggested the notion of 'self-determination' (as well as 'competency') were oversimplified in social work practice and in elder abuse literature. The simplistic binary thinking apparent in 'she has mental capacity, won't leave, so what can we do?' could mean an abused elder remained in a life threatening situation. Bergeron found mental incapacity was cited as the only reason to intervene. However, procedures and professional codes contain their own dilemmas, apparent in the UK as well as the

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[16] Elsewhere Pritchard (2001; 2002) has suggested workers may hide behind 'choice' to avoid risking a client relationship or acting to protect.

US. Under the code, social workers are required both to protect and safeguard the elder, *and* uphold their right to choose and make decisions. The Code of Practice for social care workers in Wales states:

> As a social care worker you must promote the independence of service users while protecting them as far as possible from danger or harm ...
> This includes:
> promoting the independence of service users and assisting them to understand and exercise their rights ...
> using established processes and procedures to challenge and report dangerous, abusive, discriminatory or exploitative behaviour and practice.

*(Care Council for Wales 2002:unpaginated)*

Bergeron commented that social workers need to think critically about the complex and contradictory values that surround the work they do. Although not referencing Lipsky, she asked whether the culture of the agency 'accepts' an elder's refusal for intervention, as a way of balancing high caseloads against resource inadequacy, observing:

> (t)he dilemma then in elder protection work is the understanding professionals have of the principle of self-determination to judge how much intervention preserves individual choice while providing victim protection.

*(Bergeron 2006:85)*

Bergeron pointed out that 'choices' facing elders who report and agree to intervention may be stark, inadequate, or unacceptable. If the alternative is 'a home', what view of that does the older person have? If the elder is physically abused, chastised, cowed, belittled or terrified by another, how will they assert the wish to leave? If the elder is worried and ashamed about what the family will think of a situation (which they may have kept hidden for decades), or concerned about the social shame and stigma of disclosing violence, abuse, assault or theft, how often will they blow the whistle on what has happened to them? Bergeron argued that good decision-making needed practice. For a person (typically a woman) who has never decided where she will live, managed her own affairs, or ever had a sense of personal control, so-called 'self determination' may be nothing more than the stuff of dreams.

The title of Fyson and Kitson's (2007) commentary on the abuse of people with learning disabilities in Cornwall — "Independence or protection - does it have to be a choice?" — questioned this binary 'either/or' thinking. They argued abuse could

only be minimised if policies reflecting choice and independence were mediated by effective measures to protect. The social policy *zeitgeist* emphasises choice and independence, and mostly ignores the need to be protected from harm. Whilst these authors were addressing themselves to institutional abuse of people with learning disabilities (reported by the English social care regulator CSCI and Healthcare Commission in 2006), similar points arise for older people, where a woolly pre-eminence of 'choice' over human rights (here to be free from abuse) can result in a passive professional head-shaking about the mistaken options vulnerable people may 'choose'.

This chapter concludes by considering the concept and manifestations of ageism, and the human rights of elders.

## *Ageism and human rights*

The term 'ageism' has been attributed by some[17] to Robert Butler:

> Ageism allows the younger generations to see older people as different than themselves; thus they subtly cease to identify with their elders as human beings.
> *(Butler 1975:4)*

In this, Butler implies 'younger generations' perceive 'difference' from those older than themselves. This begins, but does not quite, grasp the pernicious permeation of ageism into self and social identity, a process more starkly captured by Nelson (2005:207) as "prejudice against our future feared self". Bytheway laid out a more elaborate description:

> 1. Ageism is a set of beliefs originating in the biological variation between people and relating to the ageing process.
> 2. It is in the actions of corporate bodies, what is said and done by their representatives, and the resulting views that are held by ordinary ageing people, that ageism is made manifest.
> In consequence of this, it follows that:
> a. Ageism generates and reinforces a fear and denigration of the ageing process, and stereotyping presumptions regarding competence and the need for protection.

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[17] Cited in 'Ageism', a CANE (Clearinghouse on Abuse and Neglect of the Elderly) Annotated Bibliography. http://www.elderabusecenter.org/default.cfm?p=CANE_ageism.cfm. Accessed:14 08 07.

> b. In particular, ageism legitimates the use of chronological age to mark out classes of people who are systematically denied resources and opportunities that others enjoy, and who suffer the consequences of such denigration, ranging from well-meaning patronage to unambiguous vilification.

*(Bytheway1995:14)*[18]

This elaborates three features of ageism. Firstly, it originates in 'a set of beliefs' about the ageing process. Secondly, transmission mechanisms for those beliefs are 'corporate bodies' and those operating within them, whose actions result in those views being held by 'ordinary ageing people'. Thirdly, the consequences of the transmission process are fear, denigration, stereotyping; and the use of chronological age, negatively, to apportion resources and opportunities.

Bytheway's explication helpfully identifies some processes, mechanisms and outcomes that result in ageism. However, his 'actions of corporate bodies' inadequately portrays the complex interpenetration of the minute, casual, intended, unintended, institutionalised manifestations of ageism. Crimes like assault, rape, and theft for example, when committed against an older person may be construed as mistreatment, and dealt with by social services "concerned to *rectify* problems rather than to *enforce legislation*" rather than through the criminal justice system (Brogden and Nijhar 2000:13, emphasis in original). Awareness of elder abuse in the UK, and recourse to the criminal justice system to protect elders, has lagged far behind provision and legal remedies for victims of domestic violence (Filinson 2006), although the CPS has acknowledged "that ageism may provide the backdrop where crimes against older people are tolerated" (CPS 2008:10). Further, negative stereotypes of ageing become internalised by older people themselves, who strive to minimise impacts of ageing, and instead seek to emphasise culturally valued attributes such as youthfulness, vitality and health (Minichiello, Browne and Kendig 2000).

Tackling the social exclusion of older people and ageism has been identified as key responsibilities for the public sector (ADSS 2003; Audit Commission 2004), albeit not ones that service planners and managers have operationalised in the design and

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[18] This definition was first developed by Bytheway and Johnson (1990).

day-to-day delivery of public services (Roberts, Robinson and Seymour 2002). In social work with older people for example, work has typically been designed as the volume allocation of public resources, such as day centre places, meals on wheels, home care, rather than intervention requiring high order professional skills (Hugman 1994). Casual conversations with social workers often lead to their describing their role as being on a production line, where they process assessments, fill in forms and then move on to the next referral to repeat the operation.

In what may yet come to be labelled 'institutional ageism' is day-to-day practice in health and social services where a person's age determines the treatment or response given, rather than the condition or presenting need they have, irrespective of age. A GP may not be called to a care home when an older person has breathing difficulties until the situation becomes an emergency, which initially it was not. Ageism underpins an inert acceptance that 'old people die anyway', militating against finding out *why*, for example, an older person died of septicaemia. A death certificate can passively record septicaemia as cause of death, without reference to the neglect that caused acute pressure sores, and the subsequent onset of septicaemia (AEA 2007a).

Further, institutional and professional power are intrinsic features of health and social care services and those who work in them. Dependency on these services and professionals, on the way they work, how they work and what they expect of service users, powerfully shape the behaviours and responses of elders. This is often construed as 'old people don't like to complain'. As FitzGerald of the charity Action on Elder Abuse said in his evidence to the parliamentary Joint Committee on Human Rights, this more likely reflects the powerlessness of the elder, relative to service systems that operate to *condition* passivity in those they are paid to support, treat and care for (AEA 2007a). It also reflects what Lloyd (2006:1183) has called an "abhorrence of dependency" in some western cultures, where independence and autonomy have assumed superordinate social status and value. Lloyd noted:

> (w)ithin contemporary organisation of social services for older people, the need for care is regarded as characteristic of the weak and needy, to be corrected and controlled, rather than accepted for what it is – a part of our nature".
>
> *(Lloyd 2006:1184)*

To Lloyd's 'abhorrence of dependency' we might also add — at least in early 21st century UK — a cultural abhorrence of ageing, be it difficulties with walking,

seeing, hearing, the sight of skin that is frail, wrinkled and blotched, or the dementing presence of a person once known but now a stranger. The concretion of abhorrence around the fears of dependency and ageing play out in many ways. For elders requiring support, and care (and as Lloyd (2006) argues, that is a core, universal feature of what it is to be human), manifestations of abhorrence are neither subtle nor hard to locate.

The principles and articles of the European Convention on Human Rights (ECHR), the UN Declaration of Human Rights and the UN Principles for Older Persons (2000) based on it, neatly encapsulate the gulf between those principles and the day-to-day lived reality for many elders. Ellis' (2004) study, carried out between 2001 and 2003 on welfare providers' attitudes to the Human Rights Act 1998 reported, *inter alia*, the conditional, individualistic, view of human rights amongst social workers who worked with older and disabled people in three local authorities in England. Service users being self-reliant, autonomous and less dependent on services were emphasised; the views reported were striking for their lack of understanding about the potential of the Act to safeguard and promote the rights of vulnerable elders, or of their statutory duties under the Human Rights Act. The majority of local authorities had not at that time adopted a strategy for human rights, and the Act had "not left the desks of the lawyers" (Audit Commission 2003, para 12). Four years later, the JCHR, reporting on the human rights of older people in healthcare, commented that "bar some notable exceptions ... things do not appear to have changed very much"[19] (JCHR 2007a, para 129).

The work of the Equality and Human Rights Commission (EHRC), set up in October 2007, is expected to be informed by the UN Guiding Principles for Older Persons. As of September 2008, no information had been published on the Commission's website about its plans to address its remit on age, ageism or age discrimination. As part of this research, I wrote a personal letter to the Chair of the Commission, on university letterhead, to seek this information. The letter never received a reply. In Wales (eight

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[19] The social care inspectorate in Wales, for example, made no reference at all to human rights in its 2005-06 annual report, despite reporting an increase of 20 per cent in adult protection investigations (CSIW:2006).

months after the EHRC started work), the Commission's first published work programme committed, with no timeframe specified, to "use our integrated mandate for promoting equality in the areas of age ...". Its action to further this amounted to meeting "key stakeholders (for) scoping discussions on sexual orientation, religion and belief and age issues" (EHRC 2008:7). None of its key strategic actions for 2008-09 developed this, even though many human rights breaches experienced by older people are exacerbated by ageism. This 'invisibility' of age, reflected here in the apparent lack of urgency accorded it relative to other forms of oppression, is rendered unsurprising if only because of its pervasiveness.

In healthcare, the then Lord Chancellor's promise of a 'human rights culture' (Age Concern 2007) to be ushered in by the Human Rights Act 1998, has yet to be realised in healthcare for older people. Whilst all public authorities must act compatibly with the ECHR, and case law has placed a *positive* obligation on authorities to safeguard human rights, the Joint Committee Report on the Human Rights of Older People in Healthcare (JCHR 2007a) was often scathing in its judgement of the way older people were treated in hospitals and care homes[20]. For example, witnesses to the JCHR variously reported older people suffering from malnutrition and dehydration, lack of dignity for personal care, neglect, poor hygiene, inappropriate medication, physical restraint, bullying, patronising and infantilising attitudes, ageism. These were reported in *regulated* services, subject to inspection by regulators, not agencies or people operating in some twilight zone of informal ad hoc care. Further, only days before the JCHR report was published, the BBC reported the eviction from a care home of Esme Collins, aged 103, because the local authority and care home disputed the 'amount' — for which read the *cost*— of care the woman needed (BBC News 2007). Whilst not referring to this case, the JCHR strongly condemned evictions of older people from care homes, or the separation of married couples forced to live in different care homes, comparing the unfavourable lack of protection elders have with that enjoyed by any tenant of rented accommodation.

The JCHR (2007a, paras 66-95) noted a "significant distinction" between the 'duty to provide' under the Care Standards Act 2000 (and its associated national minimum

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[20] The JCHR report was concerned with healthcare in England; there is little reason to believe the issues it raised would not be found in Wales or elsewhere in the UK.

standards), and the 'right to receive' under the Human Rights Act 1998. National minimum standards (NMS) in England or Wales do not make explicit that people living in care homes have a legal right to be treated with respect for their dignity – a right conferred by the Human Rights Act 1998, and enacted before the introduction of NMS. The failure of healthcare providers to provide routine, regular training in human rights for all staff — clinical and non-clinical — was, the committee suggested, a feature of a prevailing belief that within healthcare, human rights were only something for the legal department (JCHR 2007a, paras 210; 222). Significantly, none of the professional codes of practice of the General Medical Council, General Social Care Council[21] or Nursing and Midwifery Council, refer to human rights principles; yet it is to these codes that professionals are expected to adhere as a condition of registration.

Human rights, arguably, matter most to those who are vulnerable and dependent on public services for healthcare and for meeting basic needs like eating, keeping and feeling clean, and using a lavatory. Underscoring the invisible impression human rights have had on healthcare for older people, the JCHR (2007a: 3) called for "an entire culture change" in healthcare services, leadership and management to tackle the poor treatment, neglect, abuse, discrimination and ill-considered discharge too often experienced by older people. The JCHR concluded:

> In our view, elder abuse is a serious and severe human rights abuse which is perpetrated on vulnerable older people who often depend on their abusers to provide them with care. Not only is it a betrayal of trust, it would also, in certain circumstances, amount to a criminal offence.
>
> *(JCHR 2007a:92)*

The strong words of the Joint Committee end this chapter, which has reviewed key literature on elder abuse policy and research, including definitions and prevalence, and has discussed thresholds for reporting abuse, ageism and the human rights of elders. The following chapter shifts gear to describe the research and the case studied.

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[21] This is also the case in Wales (Care Council for Wales, *Code of Practice for Social Care Workers*, 2002).

# Chapter 4 Research methods and case description

This chapter is in three sections. The first gives the rationale for the case study method. The second describes how the research was carried out, and the case in more detail. The third section comments on the research design, methods, data sources and data analysis processes.

## *Case study method and design*

This research was a case study of implementation of adult protection policy and procedures in a social services department. The case study method was chosen because the research aimed at revealing understanding of a contemporary issue in a real life context (Yin 1994).

## The method

Yin defined a case study as:

> an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.
>
> *(Yin 2003:13-14)*

Verschuren expanded this, noting the case study is:

> holistic in nature, following an iterative-parallel way of proceeding, looking at only a few strategically selected cases, observed in their natural context in an open-ended way, explicitly avoiding (all variants of) tunnel vision ... and aimed at description and explanation of complex and entangled group attributes, patterns, structures and processes.
>
> *(Verschuren 2003:137)*

The case study method was used in this research for five reasons. Firstly, the 'holistic' nature of a case permitted illumination of 'what' 'how' and 'why' adult protection decisions were taken, and the identification of patterns and processes at work. Secondly, illuminative research offered the possibility of drawing out the dynamics of key behaviours and attitudes in a given context (Hart 1998). Case study data can provide insights that elucidate "opaque connections" (Mitchell 2000:183), thus serving what Rist (2000:1003) termed "an enlightenment function". Thirdly, as Becker (1971:86) observed, "every group maintains fictions about itself". A case

study can reveal differences between the street level reality for workers, and the 'public' image presented. Fourthly, a case study is appropriate in complex situations that require the researcher to delve into the context and explanations, stories and narratives of the actors (Dopson 2003). Finally, as the goal of this research was exploratory, a case study offered the possibility of analytic generalisation from the stated conceptual base (Yin 1994).

The case study method has, though, potential drawbacks. Two particular criticisms are made and concern generalisation, and the reliability and validity of the method (Mitchell 2000; Flyvbjerg 2006). In terms of generalisation, Gomm, Hammersley and Foster (2000) suggested that case study researchers either dismiss generalisability as irrelevant or, conversely, are unclear about the basis on which they claim general relevance for their findings. Whilst far from dismissive about the case study method, they argued that case studies may fail both to capture the heterogeneity of the population under scrutiny, and to examine ways in which the case may be typical or atypical of others. In their seminal paper, Campbell and Stanley (1972), also criticised the single group case study as lacking in control groups and means of comparison.

Undue emphasis on either the need for generalisation, or exaggerated claims for the generalisability of a case study, however, misunderstand the case study method (Flyvbjerg 2006). Firstly, a case study does not seek to generalise to another similar population or case, but to the conceptual framework used (Yin 2003). As Stake (2000) remarked, the purpose of the research using the case study method is to present the case, not the world – in other words, to report the case's context, issues and story. Campbell, despite his earlier criticism of the case study method, later came to the view that the concepts used in a case study by "an alert social scientist who has a thorough local acquaintance" can generate findings on "aspects of the culture (being researched)", the process being "a kind of pattern matching" (Campbell 1975:181-182). Or, as Stake (2000:445) advised: "(p)lace your best intellect into the thick of what is going on", in other words stay alert, observe, listen and engage.

A second criticism of the case study method – its lack of sufficient reliability and validity – is based on a misconception of extrapolation from one case to others. The rationale of extrapolation derives from and involves statistical inference, and statements about the confidence to be had in data collected. Case studies do not

depend on statistical inference, typicality or representativeness, but rather on sound conceptual reasoning and an analytical cogence in examining the story the case tells (Mitchell 2000). In this research, the questions were concerned to uncover the views and stories of actors, and to examine what Lipsky's concept of street level bureaucracy might have to offer in understanding these. This process required rigorous case study design and execution, and these are discussed next.

## The design

Yin (2003) differentiated between single and multiple case designs and, within each, 'holistic' and 'embedded' case studies. The findings of multiple case designs are typically seen as more compelling than single case designs. However, a multiple case design has potentially significant resource implications: access issues and analysis are more complex; contextual variables more prolific. For example, social services departments in Wales each had a multi-agency adult protection committee. The remit of these committees typically included the strategic, inter-agency management of adult protection in that area, but their terms of reference varied from one to another in Wales[22]. To have included more than one social services department would have introduced far more contextual variables, for example different local operational guidance on using the adult protection procedures; different AAPC remits. Using one social services department in a single case design minimised the danger of 'reductionism', or of isolating people from their relationships, organisation and operational context (Dopson 2003).

This research therefore used a single case design of a 'revelatory' case as little research was available on street level implementation of procedures to protect vulnerable elders. The following section describes the case and how the research was carried out.

[22] I knew this as I consult on these matters to agencies across the regions of Wales.

## *How the research was carried out*

### Selecting the country

The case studied involved a social services department in Wales. Wales, as opposed to one of the other UK countries was selected for four reasons. Firstly, the population of Wales is ageing faster than any of the other UK countries. The country's general population is expected to grow by around three per cent between 2000 and 2020; the number of people post-retirement age is projected to grow by 11 per cent, almost four times as fast. The number of very old people (85+) is projected to rise by a third over the first two decades of the 21st century (WAG 2003:10). Frailty, vulnerability and poor health are risk factors implicated in the incidence of elder abuse (O'Keeffe *et al* 2007). Learning from a case in Wales was therefore of interest when examining factors that bear on decision-making when adult protection alerts were received.

Secondly, Wales was the first country in the UK to agree a national strategy for older people (WAG 2003). The ten-year Strategy, grounded in the UN Principles for Older Persons (UN 2000), acknowledged continuing problems many older people in Wales face related to ageism, stereotyping, isolation and poverty. Relatedly, the first of the ten standards in the National Service Framework for Older people in Wales (WAG 2006) concerned 'rooting out age discrimination'. Further, the world's first Commissioner for Older People took up post in Wales in 2008, with responsibilities that include eliminating age discrimination, age advocacy and support to older people and encouraging best practice in the way older people are treated. Given the remit of the Commissioner and increased interest by politicians and policy makers in Wales in ageism and the human rights of older people, any impact of this on the street level was of interest.

Thirdly, as we have seen, the first UK survey of the prevalence of elder abuse reported 6 per cent of older people aged 66 or over in Wales had experienced abuse in the previous 12 months, the highest prevalence rate in the UK (O'Keeffe *et al* 2007). Looking at the street level implementation of policies to protect elders in an authority in Wales offered the potential to explore the factors that bore on street level decision-making and how they may be related to, or affect the reporting of, elder abuse.

Lastly, the post-devolution health and social care policy context has diverged across the four UK countries. While *In Safe Hands* and the English guidance *No Secrets* shared similarities, there were key differences. English guidance included two additional abuse categories (discriminatory abuse and institutional abuse), not included in *In Safe Hands*. Unlike England, Wales had a national data collection system, where local authorities used a national format to record adult protection activity. Hence, data collected by the case study site derived from a national collection system that had been in place some time before fieldwork started, potentially reducing artefacts in data derived from recent changes in collection.

## Selecting the case

Fieldwork was planned in mid-2007. At that time there were four regional adult protection forums in Wales, each with their own set of multi-agency procedures. To reduce complexity and the number of extraneous contextual variables that bore on the research, one region was approached. I had, some four years before, drafted these regional procedures with the agencies, and so had some familiarity with procedural intentions but not implementation. The potential difficulty of my being seen as 'checking up' on practice was not great as many managers involved in development of the policy had left their posts in the intervening four years. Other regions in Wales were not approached for reasons that included my revision of one region's policies in 2006 (and the consequent risk of being seen as too closely identified with them), and the resource implications involved in accessing an authority in the other two regions.

The social services authority I approached was one of several in the region working to a set of multi-agency adult protection procedures. I had consulted to this Authority in the past, although not on adult protection matters. Access approaches to other authorities in the region were not progressed beyond initial consideration as, variously, authorities were either planning or implementing service restructuring that impacted on the management of adult protection, key operational contacts were leaving adult protection posts, or I had conflicts of interest between this research role and other work I was engaged on at the time access was being sought.

The Authority was formally approached in August 2007, following ethical approval by the university's research ethics committee. I wrote to the director of social services to request access, enclosing the research information sheet and participant

consent form[23]. Following telephone discussions with the director and the head of adult services, the Authority agreed access, and a set-up meeting with the head of adult services took place in September. A protocol to cover any concerns about practice that may have emerged during the fieldwork[24] was agreed with the Authority, and the researcher was given the name of a senior officer with whom any concerns could be discussed. The Authority did not have its own Authority research ethics governance protocol. I agreed not to name the Authority in the research products, to take all reasonable steps to safeguard its anonymity and, at its request, to have an informal discussion with the head of adult services when the findings were written up. This was a request I had anticipated (Bodgan and Biklen 1992) and found eminently reasonable as a *quid pro quo* for their contribution— not without risk to them— to what was, after all, an academic dissertation that may not have any immediate influence on the way they work.

At the time I noted the very straightforward process of gaining research access to the Authority. My telephone calls and emails were responded to; Authority senior managers asked engaging questions ("how do you see this helping us?" — "don't know— it may not"; "how will this help older people?" — "understanding more about policy processes may assist implementation. But then again it may not. It all depends ..."). Authority managers and staff suggested forums, people and meetings I could meet or attend, and offered to arrange for me to talk to other local authorities in the region. While this wasn't consistent with my research design or the resource available, I was struck by what I noted in my research diary before fieldwork started: " (senior manager) seems very positive ... very keen to help. I'm struck by what this may say about the culture ... openness? Will this be the same on the frontline?"

Fieldwork started in October 2007 and was completed by May 2008. I approached respondents initially by email followed by a phone call, and sent the research information sheet (see appendix 1), a participant consent form (appendix 2), and a

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[23] All forms, topic guides and research schedules used are in the Appendices.

[24] I am a Registered Social Worker. Compliance with the profession's Code of Practice requires use of "established processes and procedures to challenge and report dangerous, abusive, discriminatory or exploitative behaviour and practice" (Care Council for Wales, 2002).

copy of the email agreeing access sent by the head of adult services to Authority staff. (The latter had earlier been circulated to all staff when research access was agreed). The research information sheet made clear that all steps to anonymise data would be taken but that confidentiality was not guaranteed, and anonymity was not absolute. It was explicit both that serious practice concerns would be reported to a named manager in the Authority or the head of adult services, and that participation was voluntary and could be withdrawn at any time.

## Description of the case

In 2006, the population of the Authority was, as elsewhere in Wales, an ageing one. The proportion of those aged 75 and over had grown by over a third between 1991 and 2005. The number of people aged over 85 was projected to rise by a half between 2001 and 2011, correlated with a rise in limiting long term conditions. In rural parts of the Authority, a high proportion of people aged 75 and over lived alone (internal Authority document).

The Authority's head of adult services line-managed a third tier management post, whose remit included the strategic coordinator function under the adult protection procedures. The strategic coordinator managed the Authority's adult protection coordinator. Three community care teams, each with a team manager, worked with adults (disabled people and older people aged over 65). Within these teams, social workers typically worked either with younger disabled adults, or people aged 65 and over. Each team had a senior practitioner who supervised some workers and held more complex cases, as well as, variously: occupational therapists; carer assessors; social care assessors and administrators.

## The Authority's adult protection policy and procedures

The Authority's multi-agency adult protection procedures had been developed regionally in line with *In Safe Hands*, guidance issued by the National Assembly for Wales in 2000 under section 7.1 of the Local Authority Social Services Act 1970[25]. *In Safe Hands* required social services departments to take the lead role in

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[25] Section 7 guidance requires local authorities to act under the general guidance of the Secretary of State.

coordinating the development of local adult protection policy guidance, and required agencies and organisations[26] to work cooperatively to identify, investigate, treat and prevent abuse.

The regional procedures agreed by the Authority in 2003[27] related to all vulnerable adults, and used the same definition of vulnerable adult as *In Safe Hands* (2000:14), that is:

> a person 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and is or may be unable to take care of him or herself, or is unable to protect him or herself from significant harm or serious exploitation.

Older people receiving or eligible to receive services therefore potentially fell under this procedure.

The Authority's policy stated its roots in the principles of the European Convention on Human Rights and the Human Rights Act 1998. The policy defined abuse as a

> violation of a person's human, civil or legal rights by another person or persons. Abuse may be a single act, repeated acts and/or multiple acts. It may be physical, verbal, emotional or psychological. It may be perpetrated as a result of deliberate intent, negligence or ignorance. Incidents of abuse may be one person or more than one person at a time. Abuse may be an act of omission (failing to act) or neglect. Abuse may involve the vulnerable adult being persuaded or forced to enter into a financial or sexual arrangement to which they have not, or could not, consent. Abuse can occur in any relationship. It may result in significant harm or exploitation of the vulnerable adult.

*(Internal Authority policy, pp12-13)*

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[26] Agencies and organisations identified in the national guidance were health and social care commissioners, health and social care providers, sheltered and supported housing providers, service regulators, police and law enforcement agencies, and voluntary and private sector interests. (NAfW 2000:5).

[27] The signatories to the regional procedures were: the local authorities in the region and the co-terminous local health boards; a NHS Trust; the region's police authority; the Care Standards Inspectorate for Wales (Care and Social Services Inspectorate for Wales following merger with the SSIW in April 2007); and the regional umbrella body of voluntary organisations. (Specific numbers and names are not provided to safeguard the anonymity of the case study site).

## Adult protection: structures, processes and policy implementation

Regionally, the Adult Protection Forum was responsible for the strategic management and review of how the procedures operated across the region[28]. In 2006, the Authority formed its own AAPC; previously it had been part of a tri-partite AAPC arrangement[29]. Under the procedures, the role of Designated Senior Officer (DSO) included responsibility for coordinating the adult protection case, chairing meetings and liaising with other agencies[30]. The strategic coordinator role involved responsibility for strategic implementation and management of the procedures in the Authority. The procedures themselves set out a six-stage adult protection process. This research was mainly concerned with actions a social worker or their manager took when an alert was raised (Stage 1). Stage 2 was the adult protection referral, which had to be made within 24 hours of the alert[31].

The Authority began policy implementation in 2004, agreeing its implementation work plan in 2005. The implementation group comprised those who, in 2006, formed the membership of the Authority's own AAPC. The first implementation plan set five objectives: awareness raising about abuse and the procedures within organisations and the general public; developing staff competence in using the procedures; effective policy implementation at the front-line; developing documentation and data management systems; and developing inter-agency partnership work (internal Authority implementation plan, 2005).

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[28] The Adult Protection Forum was responsible for, *inter alia*, scrutiny of the effectiveness of the procedures, supporting systematic audit and review of local operation of the procedures, and work to establish and respond to the needs of vulnerable adults during and after investigations. It met quarterly and comprised AAPC chairs and others working at a strategic level in partner agencies.

[29] The Authority's AAPC was chaired by the head of adult services and comprised members from social services (the strategic coordinator, adult protection coordinator, training manager, and a commissioning manager), and a manager from the LHB and NHS Trust respectively, two inspectors with the sector regulator; and one police Detective Inspector. Meetings were held quarterly.

[30] In the Authority, DSOs were the team managers of community care teams.

[31] The remaining stages of the procedures were: Stage 3, information gathering, discussion with other agencies as needed; Stage 4, the Strategy Meeting; Stage 5, the investigation; and Stage 6 the adult protection case conference and protection plan.

The implementation plan had been agreed following the permanent appointment of the adult protection coordinator in 2004. The Authority had a chequered history with this post. Three people had occupied it part-time, with a gap for many months due to the sickness of one post holder. When fieldwork for this research started in 2007, the third internal, temporary and part-time appointment was in place.

The following and final section of this chapter describes the research approach and design.

## *Research design, methods and analysis*

A constructivist approach — where I set out to understand the social world of the street level bureaucrats and policy makers— guided the research design. Constructivism helps us consider the processes involved in the creation and maintenance of social worlds, and the meanings people ascribe to situations. These processes, as Charmaz (2000:521) pointed out, are dialectical: people actively interpret their situation and confer meanings that frame actions. These interpretations are informed by individual biographies, trainings, experiences and what Abma (2005:392) calls "pre-assumptions". The researcher of course brings her prejudices, values and experiences to the enterprise of discovery. Abma remarks that these are not negative, but awareness is necessary to understand the researcher self within the emerging account.

Using this approach, the research was designed with three elements in mind. The first was exploratory – to explore the relevance Lipsky's concept of street level bureaucracy has in policy implementation and social work practice in Wales in the early 21st century. The second element was descriptive, to describe what happens and why it happens, and how street level bureaucrats and policy makers understand what happens. The third was explanatory, that is to explain factors bearing on practice and policy implementation as described by social actors, and interpreted by the researcher within the stated conceptual framework (Marshall and Rossman 1999). As Verschuren (2003) recommended, the emergent research design was adjusted iteratively, as events, opportunities, and data emerged during the research.

## Methods

The methods used to obtain information were semi-structured one-to-one interviews, focus groups, observed meetings and discussions, and documentary analysis. The rationale for and limits of each method are shown in Table 4.1.

Overall, the decision about what data collection methods to use was guided by the questions the study sought to address. Methods needed to uncover differences between real and stated practice, whilst being mindful of the 'politics' of organisations (Marshall and Rossman 1999). Interviews and focus groups were the main data collection methods as they can uncover differing perspectives and practices, and describe complex interactions and sensitive topics (Kitzinger and Farquhar 1999). Whilst all data are context-bound in qualitative research (Whyte 1982) and the same people may answer questions differently in interviews and focus groups (Barbour 1999), the mix of interviews and focus groups (and of professionals taking part) can improve the reliability of the methods.

This mix also sought to minimise potential problems inherent in interviews and focus groups. In interviews, interviewees may rationalise behaviour, avoid saying what is inconsistent with their self and professional image, and may fear being 'shown up' (Fielding 1993). In focus groups of professionals, people are likely to know each other, and professional dynamics and stereotyping may be covert if not explicit (Marshall and Rossman 1999). These issues are not so much 'problems', as features of the complexity of human behaviour and attitudes. They require interviewer skill and flexibility to adapt the method to the situation (D.L. Morgan 1997). Further, interviewing elites requires asking broad, intelligent and provocative questions (Marshall and Rossman 1999). I knew from past experience that 'good' questions are those that get in and to the point quickly (elites don't typically spend time on small talk or small questions). I used the 'busyness' of the person to interrupt gently when responses seemed obfuscatory ('I'm sorry to cut in here but I know you need to finish soon, could I take you back to ... ?'). These strategies were used within the methods chosen for this study.

**Table 4.1 Data collection methods: rationale and limitations**

| Research method | Rationale | Limitations |
|---|---|---|
| Semi-structured interviews | These allow the same topics to be explored each time, and can be focused and valuable "strategies of discovery" (Fielding 1993:136), permitting exploration of the interviewee's perspectives and understandings (Burgess (1982).<br><br>They provide greater potential to elicit 'private' *cf.* 'public' views.<br><br>They give the researcher freedom to alter order, probe and develop perceptions from information and account given (Fielding and Thomas 2001). | Potential interviewer bias can be a problem, especially as interviews were carried out by one person.<br><br>Recall may be inaccurate.<br><br>Response reflexivity may occur (where the interviewee says what they think the interviewer wants to hear). |
| Focus groups (teams and AAPC) | Similar topic areas can be explored as in semi-structured interviews, to gather different perspectives about factors that bear on decision-making when adult protection alerts are received (Kitzinger and Barbour 1999; Krueger 2000).<br><br>They allow observation of group culture and interaction. | Group dynamics can influence responses, eg, 'groupthink' may eliminate individual differences and give pre-eminence to the views of dominant people, even if these are in a minority.<br><br>'Quiet' team members require sensitive encouragement to participate, which may lead to response reflexivity.<br><br>The researcher may miss or misconstrue some non-verbal or group behaviour. |
| Direct observation (meetings and interactions) | Naturalistic observation allows events in real time to unfold and be observed, providing context and insight into conversations, cultures and operations. | What is observed is selective. Reflexivity is a risk, where what is observed is 'different' than if it were unobserved. (Yin 2003). |
| Document review | Agency recorded data can be analysed, (eg, number of referrals; progress of referrals and types of abuse) and trends identified.<br><br>Identify trends may be affected by changing views, values and practice at street level and management level.<br><br>Documents provide broad, unobtrusive coverage; they exist outside and are not created for the case study (Yin 2003). | Annual reports are out of date and may be incomplete.<br><br>Information may be biased, selective or inaccurate.<br><br>Data may be unreliable and invalid, and not cleansed of inaccuracy. |

## Topic guides

Following the advice of Sidney and Beatrice Webb, topic guides for interviews were designed to allow a 'conversation with a purpose' (Webb and Webb 1932, cited in Burgess, 1982). I did not regard interviewing as a neutral data collection tool in some post-positivist kitbag. As Haraway (1996:259-260) has pointed out, accounts of the real world do not depend on a *logic* of discovery (my emphasis) "but on a power charged social relation of 'conversation'", driven by – Haraway again – the "situated knowledges" of interviewer and interviewee. As Haraway argued for an epistemology of location of positioning or situating knowledge, my own 'situated knowledge' needed examination before and throughout the project. (I discuss this further below).

Another consideration was the research subject matter. Abuse (or violence) is a sensitive research topic, defined as Lee and Renzetti (1990:512) as

> one which potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding and/or dissemination of research data.

'Sensitivity' is not absolute (researching abuse may not be sensitive if one is carrying out a literature review or theorising about power, for example) but rather lies in the relationship between the topic and its social context (Lee 1993). Sensitive research is made additionally difficult because of vested interests, powerful people and institutions (Lee and Renzetti 1990). Becker's (1998:91) advice to the researcher — question everything anyone in power reports, as "social organisation gives them reason to lie"— gave me a starting point (even though the Authority's response to the research was refreshingly open). In interviews, I asked '*how did you come...?*' not 'why'; probed a respondent that said 'must', by asking '*or else what*'?; and questioned the distinctions respondents made, eg, 'this/that', 'them/us' to illuminate characteristics that underlay shorthand descriptions.

Because of the sensitivity of this topic, it was important to lay the ground with potential participants in order to create rapport (Bogdan and Biklen 1992). Presenting the study and the researcher needed care. I anticipated difficulties if I presented the research as looking at 'street level bureaucracy' and the differences between policy intention and implementation at the frontline. Using my professional 'nose' and experience of consulting to public agencies, I was pretty sure people would have

seen this as checking up on their practice – 'are you doing it as the procedures (which, incidentally, I drafted) intend?'. Clearly this would have taken the enterprise nowhere. Instead I, authentically, described the project as looking at the constraints, realities and dilemmas the frontline face when dealing with the potential abuse of an older person. In addition, the presentation of me, needed some thought. As someone who had worn the 'consultant' label for some years, and who worked with national policy makers and regulators, there was the risk I would be seen as 'a suit' or 'an inspector'. To mitigate that I paid careful attention to how I presented myself. An academic? A social worker? A consultant? Should I dress up or down? The decision was of more than passing sartorial concern, as once a researcher's "presentational self" is set, so too are the influences on the progress and hence outcomes of a study (Fontana and Frey 2000:655). As it was, I dressed to blend in with whoever I was seeing. I told people I was a registered social worker, a consultant doing some part-time, unfunded, unsponsored research to pursue my professional interest in this area.

Nonetheless, I sensed I may have been seen as an inspector by some frontline staff. In one team office there were jokey references to 'make sure you make her a good cup of tea' which I interpreted as 'keep her sweet'. In another, the team manager whom I'd interviewed the day before passed me in a corridor muttering, 'POVA? What POVA? Never heard of it?"[32]. Overall, I sensed from other's concerns, for example, about was I 'getting what I wanted' or apologies that social workers hadn't had a lot of experience of adult protection, that the frontline reflected both the culture and the context of 21st century social work. That is, they knew they were publicly scrutinised, and open to challenge, judgement and assessment. I explore this further in chapter 6.

## Data sources

People in the study group were the primary data source, and documentation the secondary source.

The study group comprised, firstly, social workers and their team managers working with older people in community care teams (in Lipsky's terms, 'street-level

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[32] 'POVA' is street level vernacular for the protection of vulnerable adults policy and procedures.

bureaucrats') and, secondly, managers (who included the head of adult services and AAPC chair, strategic coordinator, group manager and adult protection coordinator).

Whether or not to interview older people was considered carefully. The decision was driven by the research questions, which were concerned with factors influencing social workers in their implementation of policies to protect older people. We might surmise that those factors could include the older person's presentation of their abuse, for example if something were said, intimated, hinted at; if behaviour or health changed in unexpected or inexplicable ways. However, adding in a further, highly complex dimension to research that was in any case exploratory, would have been overambitious and beyond the resource and scope of a lone researcher enterprise.

My research plan was to interview street level bureaucrats first, and managers subsequently, so that I could tease out similarities and differences in understandings about the intention and operation of the procedures.

Thirteen one-to-one interviews lasting between one and 1.5 hours were held with managers (4) and street level bureaucrats (9), as shown in Table 4.2.

**Table 4.2 One-to-one interviews**

| One-to-one interviews | Number |
|---|---|
| **Managers** | |
| Head of adult services and chair of AAPC | 1 |
| Adult protection coordinator | 1 |
| Strategic coordinator | 1 |
| Third tier manager (job share partner of strategic coordinator) | 1 |
| | **(4)** |
| **Street level bureaucrats** | |
| Social workers | 3 |
| Senior practitioners | 3 |
| Team managers | 3 |
| | **(9)** |
| **Total** | **13** |

## Focus groups and observed meetings and discussions

I held focus groups with two of the three community care teams, using a topic guide (see appendix 6) broadly similar to that of one-to-one interviews with street level bureaucrats. Both focus groups were tape-recorded. (Arrangements made with the third team are discussed below).

To set up the first focus group, I asked for an hour with the team. However, teams included people not working with elders (for example, social workers working with young disabled adults), so some people in this group felt they had little to contribute to the discussion. Consequently, when arranging the next focus group, I asked to meet with a smaller group (three people) of social workers and senior practitioners all of whom worked with older people.

Strategically, I observed one quarterly AAPC meeting, with a 30-minute focus group at the end. This used a topic guide (see appendix 7) that explored areas emerging from the earlier fieldwork.

I opportunistically took up offers to observe meetings not in the original research plan. Early on, one team manager told me their team held periodic practice discussions to reflect on practice issues and cases. As naturalistic observation can often bring to light issues, aspects of workplace cultures and ways of working that facilitated focus groups may not, I took up the team's offer to attend one of these as an observer, favouring this over running a focus group with them. This discussion was not taped because of the physical layout of the room we were in.

In addition, I learned at the start of the research that the Authority held quarterly multi-agency practice forum meetings, open to managers and practitioners and others engaged in adult protection policy implementation, management or operations within the Authority. My request to attend as an observer was agreed. Again, this was not taped as the group, and the room, were too large to obtain an audible recording.

Five focus groups (or meetings) were held, at which 33 social services staff were present, as shown in Table 4.3.

In all, 34 social services staff took part in an interview or group: three people were seen three times in various forums; six were seen twice. As the Authority was small, I had contact with everyone I intended to, and no sampling or selection decisions

were required. Further, I noted in my research diary after completing most of the interviews, that "nothing new (is) coming up ... category saturation now I think". This suggested I did not need to pursue any other data sources.

**Table 4.3 Focus groups and observed meetings**

| Focus groups and observed meetings | Number of staff |
|---|---|
| Team 1 focus group | 8 |
| Team 2 observed practice discussion | 10 |
| Team 3 focus group | 3 |
| Area Adult Protection Committee | 4* |
| Practice forum | 8* |
| **Total social services staff** | **33** |

* Social Services staff only; figure excludes staff from other agencies present.

Researchers can pick up the ideas of people in the study group or, conversely, ignore the things they do (Becker 1998). To maintain my awareness, I programmed space between interviews for reviewing and analysing transcripts, to review the research plan and identify any themes insufficiently attended to. These were returned to and explored further in subsequent interviews.

To provide "richer research access" to the data (Kitzinger and Barbour 1999:15), interviews and focus groups were tape-recorded, subject to respondents' agreement. As Whyte (1982) noted, recordings can be listened to several times (some were) to review the conversation. Abridged transcriptions of recorded interviews were used as this was more time-efficient than producing full transcripts (Krueger and Casey 2000). These were coded as described below. Where a participant withheld permission for taping (one instance) I took contemporaneous notes. Three groups (two observed meetings without researcher intervention, and one focus group with a pre-arranged end-slot for researcher questions) were not taped because of the number of participants, and the physical and acoustic constraints of the venue.

Abridged transcriptions were done within 48 hours. Abridging is not unproblematic; as Atkinson (1992) observed, what is generated as 'data' may be affected by what the researcher views as 'writable' and 'readable'. I began to see how my decisions

about what to include or exclude resulted in an interview transcript that was a 'negotiated text' (Fontana and Frey 2000). Data are, as Fontana and Frey remarked, messy, contradictory, repetitive and reflexive. Keeping an open mind of course does not, as Dey (1993) observed, mean having an empty head. The question for me therefore, was not whether my *a priori* knowledge and experience was drawn upon, but *how*. To keep my eye on the data and on me (exotic, but non-relevant, quotes can be so seductive) I had several cuts at transcribing, which helped the process of understanding, and then selecting, what was in the typed and coded transcript. I did the first transcription by hand as it was quicker and allowed repetitions, non sequiturs and red herrings to be weeded out. On the second cut, the interview was typed up and coded, ready for subsequent entry into a database. Later, when I came to transfer coded text into the database, I had a further opportunity to reflect, feel and think about comments and text.

### Adjusting in light of experience

My research plan was adjusted as events and information emerged. I had considered running a discrete pilot phase before fieldwork began, and had rejected this for three reasons. Firstly, as van Teijlingen and Hundley (2001) point out, data collection and analysis in qualitative research are progressive. My research plan purposefully planned this iteration and flexibility into the overall project design and, as I discuss below, early stages allowed adjustment as part of that design. Secondly, to run a meaningful pilot requires resourcing (Sampson 2004). This project had no funding other than the time and cash the researcher put into it. Thirdly, my professional background as a researcher and consultant in the area under investigation gave me solid experience of interviewing and running focus groups. I drew on this (and actively sought advice from the research adviser to self-question and counter potential researcher bias) to adjust lines of questioning as data emerged.

Hence I anticipated early interviews would result in some adjustments. This proved to be the case: the first three interviews (two team managers and a social worker) formed a *de facto* pilot, resulting in three adjustments. Firstly, I originally intended to see the team manager and two social workers in each team. Early on a team manager told me social workers would not necessarily "come across abuse" unless working with the older person as part of a care plan (this was a useful finding both about awareness and type of work social workers do, and is reported in the next chapter). I

therefore changed tack to speak with the senior practitioner who might do the initial information gathering when an alert was raised.

Secondly, in an early interview with a social worker, it became obvious that the research purpose had been misunderstood. The research information sheet said: "*My research is interested in finding out about the realities and constraints for social workers and team managers using the 'POVA' policy to protect older people from abuse*". Even though this was followed by "The research isn't about evaluating the procedures or your practice", the respondent thought their knowledge of the policy and its forms was being researched (the word 'policy' was the problem). I changed the sheet to say *"My research is interested in finding out about the realities and constraints for social workers and team managers when dealing with concerns and alerts about possible abuse of an older person"*. This told me I had to start from where street level bureaucrats were, and not talk or write 'in academic'.

Thirdly, I had developed four vignettes to use in interviews[33] as a way of allowing respondents to consider what they would do if confronted with the situation described, without feeling their own practice was being scrutinised (Schoenberg and Ravdal 2000). Drafts of these had been commented on by academic and professional colleagues, and a professional colleague had trialled them with a multi-agency group of social workers, nurses and police officers. During the first interview I began to feel uneasy as I sensed the respondent behaving as though on a training course ('talking the talk'), and speaking as though writing a report rather than conversing. For example, in considering a vignette involving potential domestic abuse of a mother by her son, a team manager spoke thus:

> In that sense, capacity plays a major part in terms of the risks to which she's prepared, apparently, to expose herself through her contact with her son. If it is felt she does not have capacity to be making rational decisions about the risks that are posed by her son, then it would seem to me we would be almost certainly be in a POVA situation.
>
> *Team manager*

In the second interview, again with a team manager, the process felt even more laboured: I asked the respondent for their views. The team manager said they would

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[33] See appendix 8.

much rather talk about actual cases, the vignettes were 'hard' and somewhat disconnected from day to day work.

The vignette experience suggested two things to me. One, vignettes have value as a research tool in the right situation with the right people. However, as Rapaport *et al* (2008) note, they work best to tease out beliefs and principles rather than accounts of hypothetical actions. What I was asking people was to say what they would do; in doing this I had, despite all the attention beforehand to my presentational self, come across as an examining inspector! Second, I speculated that people were habituated to vignettes (case studies) on training. Hence when presented with them, they started to display 'training behaviour', to try and 'get it right' and appear smart, or please the trainer. My research was not concerned with how well, or how much, people knew the procedures, or with rating their professional skill – its concern was identifying factors that bore on decision-making. Vignettes may have provided a gateway to uncovering this in some situations, but they did not here. Hence they were abandoned after two interviews, the topic guides rewritten, allowing 'conversations with a purpose' to flow easily.

### Documents

I reviewed the following documents for information relevant to the research questions: adult protection policy and procedures, and related forms; the Authority's adult protection local operational guidance; AAPC terms of reference, minutes and related papers (from 2006 onwards); adult protection monitoring data (from 2005), Annual reports, 04-05 and 05-06[34]. Documents were readily supplied, but in several cases were incomplete. This is discussed further in chapter 6. I summarised information relevant to my research questions and conceptual framework on the document summary form I developed for the research (appendix 12).

### Logging the learning, displaying the data

To assist learning and data display, I kept a research diary, developed four research instruments and wrote analytic memos.

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[34] This was all the documentation the Authority had.

Following Abma's (2005) suggestion, I kept a research diary to reflect on what I was seeing, hearing and sensing, and conjectural interpretations I was making. The first part comprised observations, impressions and perceptions of interactions, conversations, behaviours I encountered whilst on site, and reflections off-site. The second part contained research management notes, including tracking notes of changes to topic guides and codes, task lists, and people and information to follow up.

The first part of the diary proved its worth early on. I was writing up impressions of the first focus group I had run that day before listening to the tape. I had felt unease at a *sotto voce* comment made about a care home that "the whole place is an abuse". This was a "sensitive moment" (Kitzinger and Farquhar 1999), where team members had nodded but said little until I probed further and gained more insight. I diary-noted my "concern about standards in care homes. Why aren't they (frontline) more proactive in challenging low level but very real abuse...why not assert professionalism as registered professionals (to challenge)?...". Aware that — if the report was correct — older people were likely to die in this home where staff were said to speak coarsely and harshly to them and about them in their presence (apart from any potential breach of dignity and respect national minimum standards), I contacted the team manager under the protocol agreed with the Authority should practice concerns arise. (The issue is discussed further in chapter 5). The reflective diary process was invaluable as I mused further on my perceptions at the time, and before and after listening to the tape.

To display data as information mounted up I developed four instruments (Miles and Huberman 1994). The information collected on these was later coded and entered onto the Excel research database I developed. The first, a contact summary form in four sections (appendix 9) noted my impressions straight after an interview, focus group or observed event. Second, a case analysis form (appendix 10) was completed a third of the way into the fieldwork, at halfway, and towards the end. Its purpose was to lift my vision away from 'the stuff' of the data to what they may be saying. Taking this process up a level was a third case themes form (appendix 11), which was completed twice in the second half of the fieldwork programme. This involved *writing down* impressions of themes and findings to date (before detailed analysis started), and *writing down* potential propositions to go in the final draft. The 'forced'

thinking and writing added stimulation to what otherwise felt like a tedious treadmill of transcription. Finally, as indicated above, the document summary form (appendix 12) tracked and summarised information from Authority documents. The mundanity of these instruments belied their value as data, paper and thoughts mounted up – they demonstrated the wisdom of "you know what you display" (Miles and Huberman 1994:93).

Finally, I wrote analytical memos and notes to capture theoretical ideas, 'what ifs', insights and other speculation, throughout the data collection and analysis phases (Glaser and Strauss 1967). These included working critiques of my own research and rudimentary theorising as work proceeded and drew on the 'dear diary' scribbling. Again the discipline of *writing down* half-formed theoretical ideas helped unblock stuck-ness (... this is going nowhere ... Lipsky said it all ...) and stickiness (thinking in grooves).

### Coding, data reduction and triangulation

As "coding is analysis", a provisional 'start list' of codes was developed before fieldwork commenced, with the aim of integrating coding and analytical processes with the emergent findings (Miles and Huberman (1994:56, 58). The research questions and conceptual framework generated the initial codes (Patton 1990). This code start list was reviewed after two interviews and one focus group as, inevitably, some codes were redundant or could be collapsed with others, or additional codes were required (Coffey and Atkinson 1996). The final list contained 58 codes.

This refinement from reflection and experience was, as others have suggested, a critical part of the research process (Patton 1987; Marshall and Rossman 1999). The discipline of transcribing and coding within 48 hours of the interview or focus group as well as completing the contact summary form, meant my impressions were fresher and my questioning of the data sharpened up reflexively. This process helped me understand Charmaz's comment that "data do not provide a window on reality" – that comes from the "discovered" reality emerging from the interactive process between data and researcher within the temporal, structural and cultural context of the research (Charmaz 2000:523-524). Hence, content analysis of transcripts and documents was an iterative-parallel process, where the different research activities generated insights related to the questions the research sought to address. The

research questions and conceptual framework drove the analytic process, which helped guard against the 'everything looks interesting' pitfall.

After data collection was completed, the coded parts of the abridged transcripts, the coded instrument sheets (appendices 9-12), along with coded extracts from my research diary and analytic memos, were entered into the Excel database I developed (Hahn 2008). Following Hahn's helpful data reduction processes, these 'level 1' codes (numbering 58) were reduced into 38 categories (level 2 codes). These were further reduced into five analytic themes (level 3 codes) by creating "affinity groups" (Hahn 2008:164), or clusters of related categories. This incremental reduction was logical and comparative ('is this datum similar or different from others?'), and creative. The 38 categories were written on large post-it notes, and grouped and re-grouped on large white boards over several days to result in five analytic themes (level 3 codes). Throughout the data reduction process, I kept in mind the counsel that "premature analytic closure is hard to shake" (Miles and Huberman 1994:70), and I returned to 38 categories and themes they suggested several times, before settling on the five themes I report on in chapter 5. These five themes were appraised and reappraised in light of the research questions, the conceptual framework, and the 58 level 1 codes from whence they derived. Hence this systematic grounding of theory development (Glaser and Strauss 1967) derived from the analytic process itself, a process that was driven by the research questions and the researcher (rather than the computer), and intended to produce analytical "hybrid vigor" (Miles and Huberman 1994:10). Finally, logging all coded information into one Excel workbook meant data could be sorted and filtered efficiently, quotes extracted, and themes and patterns located, compared and contrasted. This assisted both the analysis and reporting processes.

### Triangulation of data and methods

Patton observed that "triangulation strengthens a study by combining methods. This can mean using several kinds of methods or data..." (Patton 2002, cited in Golafshani, 2003:603). In this qualitative research, I aimed to bring coherence, insight, and authenticity to its design, process and product. Triangulating data to identify patterns whose existence was corroborated by other pieces of information was critical, both to control potential bias (for example, in research carried out by one rather than several researchers), and to establish credible findings and

conclusions. Thus I started from the premiss that triangulation is a procedure that allowed me to search for convergence (or divergence) in the multiple sources of information obtained by the differing research methods I was using, to develop categories and themes (Creswell 2003).

I triangulated data from firstly, *what* and *who* I was looking at (different data subjects and documents) and, secondly, *how* I was doing the research (its various methods, ie, semi-structured interviews, focus groups, observed meetings, observation and documentary analysis). I compared and contrasted data by examining evidence from different sources, to develop coherent justifications for emerging themes. For example, I wanted to explore if and how discretion was exercised by social workers in local implementation of the adult protection procedures. The constructivist approach of the research aimed, explicitly to draw out the multiple realities (the stories, accounts and narratives) of street level bureaucrats and their managers. My data sources were the views, stories and accounts of *people* (street level bureaucrats and their managers), and the content of *documents* (the *who* and the *what)*. My research methods included semi-structured interviews, focus groups, observed meetings and documentary analysis (the *how*). Using, and triangulating, data from different sources, obtained by different methods, allowed me to report on the construction of realities in the Authority (for example, whether diverse, similar or conflicted), in relation to the exercise of discretion. This systematic, inductive and creative process was anything but linear and sequential, as Miles and Huberman point out:

> ... triangulation is not so much a tactic as a way of life. If you self-consciously set out to collect and double-check findings, using multiple sources and modes of evidence, the verification process will largely be built into data collection as you go ... Analytic induction, once again.
>
> *(Miles and Huberman 1994:267)*

This chapter has described the research methods and design, and the case. The next chapter presents the key findings.

# Chapter 5 Findings

Before presenting findings from this study, a reminder of the research questions is needed. The primary question was:

- What factors influence the street level implementation by social workers of policy to protect elders from abuse?

Subsequent research questions were:

- What dilemmas do social workers and their team managers face in their implementation of procedures?
- Do agency policy makers, and social workers and their team managers, share similar understandings of the intention and operation of procedures?
- What impacts do these understandings have on local implementation in terms of:
    - exercise of professional power and discretion;
    - understanding and interpretation of the elder's situation; and
    - decision-making about action taken or not taken to protect an elder from abuse?
- What can Lipsky's concept of street level bureaucracy offer in understanding local implementation of policy to protect elders from abuse?

Inevitably, the process of finding out how the case study site organised adult protection, immediately presented a difficulty with the phrasing of the primary research question. Street level implementation of policy and procedures to protect older people (where there was a concern about potential abuse) was a process that involved both social worker and their team manager. Social workers could not, alone, implement the procedures, as the team manager acting as DSO was the procedural gateway to their implementation (in conjunction with other partners to these multi-agency procedures). The research question the study focused on therefore, was the street level implementation of the procedures by the team manager and the social worker. Within this dyad, various micro processes of decision-making, ways of seeing or not seeing abuse, ways of understanding the situations of the older person were enacted. Opening this dyadic 'black box' to understand the factors that

bore on street level policy implementation became the research focus; and the findings that follow report on this, along with the subsequent research questions.

This chapter, the longest in this study, is in five sections. Each describes a major theme, or cluster of related thematic factors emerging from the data, and guided by the conceptual framework and the questions the research set out to address. The themes are: awareness and experience of elder abuse; culture and organisation; dilemmas of resources; dilemmas of care; and power, discretion and procedures.

## Presentation of findings

Illustrative quotes have been included, with transcribed data 'tidied up' by, for example, removing non-words or verbal self-corrections made by the respondent, and inserting minimal punctuation to ease text reading. I indicate where I am paraphrasing from interviews on the occasions I took contemporaneous notes; direct quotes have not been used from those discussions. Data and quotes have been anonymised. Individuals' names are not used, although three generic job titles are, as follows: *team manager*; *social worker* (including both senior practitioners and social workers); and *Authority manager* (referring to Authority managers and policy makers).

## *Awareness and experience of abuse*

This section is in three parts. Firstly, findings on adult protection activity levels are discussed, followed by those on the extent to which social workers 'see' potential abuse. Lastly, findings on awareness of domestic abuse in older age are considered.

### Adult protection activity levels in the Authority

This section considers adult abuse referral rates in the Authority. It is followed by findings on the extent to which abusive situations, whether in institutions or the private domain, are 'seen' by social workers. This section concludes with findings on the interpenetration of ageism in perceptions and management of potential elder abuse.

The low number of adult protection referrals concerning older people was striking given, as we saw in chapter 3, the nature and levels of elder abuse reported in Wales (eg, O'Keefe *et al* 2007). Decontextualised, this of course means little. At the time fieldwork for this research was done, data about numbers and types of referrals in this Authority, as elsewhere in Wales, were not considered sufficiently robust for national publication. The Data Unit Wales (the Welsh government's national data collection agency) introduced a new data collection system on a two-year pilot when it took over national adult protection data collection from the Social Services Inspectorate for Wales in 2005-06[35]. Prior to that, the quality of data collected was insufficiently robust to make any meaningful use of it. Indeed, CSSIW (n.d.) noted "there are still inconsistencies in the data used in this monitoring report and this is reflected in some of its conclusions" when it published its 2006-07 monitoring report sometime in 2008. From 2007-08 on, this Authority, as others, was required to validate its data before sending to the Data Unit, using an agreed data collection set.

The Authority itself acknowledged problems in the completeness and accuracy of its data. Two complete years' data were available to this research, 2005-06 and 2006-07. I was told there were known problems with the data, to do with their comprehensiveness and consistency of recording practice by practitioners. Some changes to data collection had been introduced in 2007-08, to comply with national

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[35] Personal communication, Chris Williams, Data Unit Wales, 4 January 2008.

reporting requirements (typically more detail was required). This, too, limited what could be reasonably inferred from Authority data over time. Hence, what follows is heavily qualified and is included only to indicate the amount of recorded adult protection activity involving older people in this Authority.

Table 5.1 shows adult protection referrals the Authority dealt with between 2005 and 2007. Over the two years 2005-06 and 2006-07, less than one-third (32 and 27 per cent respectively) of these concerned older people.

**Table 5.1 Authority adult protection referrals by age, 2005-2007**

| | MALE | | FEMALE | | TOTAL | | TOTAL ALL REFERRALS |
|---|---|---|---|---|---|---|---|
| | Adults 18-64 | 65 and over | Adults 18-64 | 65 and over | Adults 18-64 | 65 and over | |
| **2005-06** | 45 | 14 | 38 | 25 | 83 | **39** | **122** |
| | | | | | | | |
| **2006-07** | 55 | 9 | 40 | 27 | 95 | **36** | **131** |

**Source: unpublished Authority monitoring data, 2005-06; 2006-07.**

In 2005-06, the Authority adult protection referral rate for older people was the same as for people with learning disabilities (39). The following year, 2006-07, more adult protection referrals concerned people with learning disabilities (45) than older people (36). These rates diverge from all Wales data, where referrals concerning older people run at the highest rate of all adult groups, followed by people with learning disabilities (CSSIW n.d.).

In these two years, Authority adult protection referrals concerning older women exceeded those of men: in 2005-06 at almost twice the rate; in 2006-07 at three times the rate. Women were more likely to suffer every type of abuse (physical, sexual, emotional, financial and neglect); in each of these years, the highest number of referrals concerned women who had been physically abused. The most likely outcome of an abuse investigation was 'ongoing monitoring and risk management', followed by 'client/property no longer at risk' (suggesting the person or situation connected with the allegation had been removed or resolved).

Considering Authority adult protection referrals as a whole (that is, including all groups of vulnerable adults), adult protection referrals mainly came from non-social

services providers (contracted providers), and 'health and hospital' (which refers to hospital settings). Table 5.2 shows the source of referrals from 2005 to 2007.

**Table 5.2 Authority adult protection referrals, by referral source, 2005-2007**

| | 2005-06 | % | 2006-07 | % |
|---|---|---|---|---|
| Provider (non SSD) | 30 | 24.6 | 27 | 20.6 |
| Health, hospital | 23 | 18.9 | 45 | 34.4 |
| SSD care manager | 18 | 14.8 | 7 | 5.3 |
| Relative, friend | 16 | 13.1 | 12 | 9.2 |
| Self | 8 | 6.6 | 2 | 1.5 |
| Inspection | 8 | 6.6 | 0 | 0.0 |
| SSD provider | 7 | 5.7 | 8 | 6.1 |
| Health, primary, community | 6 | 4.9 | 8 | 6.1 |
| Other | 4 | 3.3 | 6 | 4.6 |
| Police | 2 | 1.6 | 3 | 2.3 |
| CSIW | 0 | 0.0 | 9 | 6.9 |
| Housing | 0 | 0.0 | 4 | 3.1 |
| DWP | 0 | 0.0 | 0 | 0.0 |
| **Total** | **122** | **100.00** | **131** | **100.00** |

**Source: unpublished Authority monitoring data, 2005-06; 2006-07.**

Together adult protection referrals from non-social services providers and health and hospitals formed 43 per cent of referrals in 2005-06, and 55 per cent in 2005-06. The elevated Authority figures on referrals from 'health, hospital' may have been influenced by the high number of referrals from a private mental health hospital. Referrals from care managers amounted to 15 per cent of those made in 2005-06, and five per cent the following year. Nationally in 2006-07, the highest rate of adult protection referrals come from social services care managers (20.5 per cent) and non-social services providers at 20.8 per cent[36]. These figures show that Authority care managers made adult protection referrals much less often than the Wales average.

Raw data collected in the first three quarters of 2007-08 (when fieldwork was underway) indicated 21 older people alerts had been received. Ten of these (almost half) were from care homes with nursing (one home generated six referrals); and five from residential care homes (three were from the same home) Seventeen of the 21 referrals concerned women. The age of the alleged victim was not available in five cases (at the same nursing care home). The age range was 66-99 where the victim's age was available. Nine (out of the total of 21) alleged victims were in their nineties,

[36] *Protection of Vulnerable Adults Monitoring Report 2006-07.* (CSSIW n.d.).

they were all women. Six of these nine women lived in care homes, two in their own home, one in warden-controlled sheltered accommodation[37].

These raw, unvalidated figures suggested the risk factors in this Authority in that time period were: living in a care home (either nursing or residential); being female; and increasing age. National data made available in 2008 indicated concerns were expressed about 3.2 per cent of people living in care homes for older people in Wales in the year 2006-07 (CSSIW n.d.).

### 'Seeing' potential abuse

The relatively low rate of referrals of suspected abuse of older people in the Authority meant street level bureaucrats dealt with alerts concerning elders infrequently. In the first three quarters of year 2007-08, just one of the 21 referrals received had been made by a care manager (unpublished raw Authority data, 2007-08). At first sight, this may reflect the relative lack of contact social workers have, in a continuing way, with older people. Unless a social work service was part of an agreed care plan, as care managers their role would typically be one of reviewing care plans:

> I don't remember a single example of a POVA type enquiry or concern being realised (*sic*) by a social worker as a result of their visit to a particular home. Our involvement with a home, once someone's in there ... it's (a) set piece really — reviews.

*Social worker*

To an extent, this reflects wider changes in the social work introduced by the NHSCC Act 1990, and the managerialism of the time, themes discussed later when the findings as a whole are reviewed. For the moment however, our attention remains with the findings.

Whilst Authority managers and teams were aware the number of referrals of older people under adult protection procedures was low, there seems to have been little focused consideration of why this was. Rather the low numbers were seen as presenting an *organisational* problem in that social workers and DSOs (team

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[37] Unpublished raw Authority data, 2007-08.

managers) had limited experience, and hence confidence, in dealing with suspected abuse of an older person. For example:

> To get into your role as DSO is quite demanding on your knowledge base and I think the problems we face is we don't get many and it's very hard to come out from being a team manager to being a DSO... we've only done about 7 or 8 (alerts) this year.
>
> *Team manager*

Social workers were not, as a rule, doing joint investigations with the police under procedures, so were not gaining experience that way. An Authority manager at an AAPC commented that "social workers are trained to assess, not investigate", implying the adult protection procedures and framework outsourced the skills of asking good questions, weighing up evidence and reaching conclusions, to those trained in something called 'investigation'. As the fieldwork progressed, the repeated asking of the research question 'why are your numbers so low, are older people safe from abuse in (Authority)', led to musing and speculation in meetings and interviews. In the AAPC the day after an interview with an Authority manager, that manager queried the accuracy of the data on reports of older people. The AAPC minute recorded "the number of incidents was probably under-reported, either through reluctance on behalf of the victim, or because of insufficient training of domiciliary care and district nursing staff". In an interview, another Authority manager was less sure the reasons were understood : "I suppose we're at the beginning of the process as to understand why that is, whether it's about awareness ..."

'Seeing' abuse – whether social workers had what one manager called a 'third eye', or a sense of something 'not-right', was raised more as the research proceeded, coinciding with a large-scale abuse investigation instigated in a care home at the time the fieldwork started. Coincidentally, a respondent in an early focus group for this research had said of this home "the whole place was an abuse ... it was awful". As described in the last chapter, I had taken this up with the team manager after the focus group as, in line with the research protocol, I needed to discuss my concerns further with an appropriate person. As it was, adult protection procedures were instigated in relation to this home that week.

Three broader points emerged from this. Firstly, social workers (and nurses) had been going to this care home to undertake statutory reviews on people their agency funded. After the alert was raised, I was told professionals spoke of their guilt in not having picked up what was, apparently, the day-to-day reality of living in a home where

> if a person got out of their chair because they were trying to attract the attention of someone ... before they (could) say anything they were told to sit down.
>
> *Social worker*

An Authority manager said the investigation

> shocked a lot of people. There's a lot of guilt around these situations. I've talked to nurses who say 'I did a review there two months ago why didn't I pick up these things?'. I've talked to social workers who say we've known for ten years (the home) is not a very great place but we've placed people there. There's a lot of guilt and discomfort around that.

The ambiguity of response though was confusing. Did professionals tacitly turn 'a blind eye' on poor practice? What were the processes that allowed professionals both to have misgivings, and yet 'not know' day-to-day life for older people was so miserable? At what point does an older person not wearing their dentures, being spoken to roughly and coarsely become, by default, 'acceptable', in that those concerns do not galvanise action? In short, what does it take to name and act on poor care and potential institutional abuse?

Secondly, even if a reviewer did not personally witness poor care, the review system itself (gathering information from the older person and significant others in their life), was intended to identify what life is like for the person, and if needs were being met in a placement. One Authority manager described reviews as "cursory at the best", and during the fieldwork discussions were ongoing about how to strengthen these processes. Thirdly, the social worker respondent quoted earlier had returned to the team and spoken at length about what they had seen, but no further action had been taken. That is, no witness statement had been made of what had been seen and heard, nothing had been said to the officer-in-charge at the time, no decision about appropriate action to take (other than describing it to colleagues) had occurred. The culture and treatment of people living in this home had not come as a surprise to social workers and team managers who knew the place:

> People have come back and talked ... about examples of swearing in front of people and things like that, just treating people with respect really. I think people are attuned to that.

*Authority manager*

Being 'attuned' though had not taken concern up a level, that is by a social worker challenging or reporting what they had seen. Another manager speculated about how far social workers felt equipped to challenge when a home may present a particular front to the reviewing officer:

> How confident do social workers feel to probe, and also when you're reviewing how much do you accept what you're told? It has raised a few questions I think, as to how we review, how you can get a more accurate picture from reviews ... How do you get a really good view of what's going on when you've got a very limited window of opportunity, how do you get behind that stage management?

*Authority manager*

Another manager viewed the issue as one of insufficient contact where social workers were not going to the home often enough to know what was going on and what life may be like for people living there. The bigger question was, though, why apparently 'low level' — but patently not insignificant — abusive 'noise' in this home (and, allegedly, others) had been tolerated by social workers by omission, that is, omitting to question 'is this how life should be here?'. Older people in this home would be likely to die there (or in another institution like a hospital): their last days would be spent in a place where coarse speech and swearing were apparently commonplace, where they were fed roughly or left without their dentures fitted. This apparent non-response was also apparent in incidents of domestic abuse and violence between family members in a domestic dwelling.

## Domestic abuse in older age

Domestic abuse in later life began to creep over the social work practice radar in the UK in the early 21st century (Lawrence 2008). The UK elder abuse prevalence study had uncovered the levels of inter-personal abuse within families, the vast majority of which was not dealt with by adult protection systems. In the Authority, no examples were given of using domestic abuse systems and procedures to protect one older person from the abuse of their partner. A professional impotence to do anything was apparent:

> A gentleman had admitted he had hit his wife. She was very upset but having spent a lot of time with them with one of my colleagues we discovered that this was how their marriage had been for 35 years. Their children were now grown up (and said) 'oh yeah, that's quite normal behaviour' (for them).

*Social worker*

This practitioner spoke of (relatively infrequent) cases where domestic abuse involving older people was managed within the adult protection framework if there was evidence of abuse or a crime being committed. Social work intervention was seen as limited as:

> We can only do so much as social workers because it does get to that point where the only way you can solve the problem is get a divorce and if they choose to live like this in their marriage then we can't control that.

*Social worker*

There were no examples of using domestic abuse support services and systems in cases of domestic abuse involving older people. The domestic violence policy of the regional police force was not linked to the POVA policy, although it was to 23 others, including child protection and victim support referral (internal police policy, 2006). Whilst individual operational referrals could be made, the POVA infrastructure (regional adult protection forum, AAPC and intra-organisational arrangements) were not linked systemically to MARAC (Multi-Agency Risk Assessment Conferences) arrangements for high risk victims of domestic abuse, or MAPPA (Multi Agency Public Protection Arrangements) systems set up to manage risk posed by certain specified violent and sexual offenders. Management of and intervention in cases of domestic abuse seemed to turn in part on the ages of those involved:

> I get the weekly emails about (MARAC meetings) but none of them to date have been about POVA older people. It tends to be much more domestic violence as being seen for younger people, perhaps older people tends to go down (*sic*) the POVA route.

*Team manager*

The visibility of domestic abuse in older age may have been masked by the significance placed on an older person's exercise of choice. When considering a

vignette[38] concerned with the contact a mother had with her abusive son, for example, a team manager commented:

> For me the issue is whether she is making informed choices ... what is she weighing in her decision-making ... We should be prepared to endorse the individual's right to make choices.

*Team manager*

Informed choice flowed from whether the person had mental capacity to make that decision. Questioning choices made, or awareness of the risks inherent in decisions, was not apparent — 'people have the right to make unwise decisions' was a phrase repeated many times in one particular team for example. The voices of older people were generally unreported, and therefore absent, when these opinions were offered; there were few examples given of exploration or discussion over time with an older person in a risky domestic situation. The extent to which professional guide posts of the times — choice, independence, personalisation — were age-blind to factors such as frailty, dependence, power were not questioned. That is, discussing cases where there were poor relationships between the older people involved seemed not to consider 'domestic violence grown old' and the power relationships therein, in the same way domestic abuse involving younger people might have done. Similarly, the UK prevalence findings on domestic abuse in old age in Wales were not mentioned. The lack of services for older people in abusive relationships had not been fully considered — in other words to ask, 'why is this'? One manager had begun to think about the ageism implicit in service design:

> We know it's blatantly ageist in terms of what we spend on residential and nursing care compared to learning disabilities and things like that. The cost differentials are not just linked to levels of need, they're linked to an assumption about what you provide for older people who no longer need *dot, dot, dot.*

*Authority manager*

The low social and cultural expectations of quality at the end of life for older people were mentioned several times by managers as a contrast to those embedded in national policy in learning disabilities. As the quote above shows, the large scale

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[38] As explained in chapter 4, vignettes were used in interviews with two team managers before being abandoned in favour of wholly semi-structured interviews.

abuse investigation underway at the same time this fieldwork was being done raised uncomfortable questions for managers about the unit cost they paid for beds in care homes, and the assumptions about what care could be provided to older people, and how, at that price level. Thinking of Blumer's (1969) advice that the researcher should try to describe how actors act towards the world they see (rather than the world the researcher sees), this seemed to be a junction where managers glimpsed – panoramically – the confluence of ageism, negative values and assumptions about old age, with procedures, policies and resource allocation that favoured community over residential provision. However that perception, or what a number of respondents called the 'wake-up call' of the large-scale abuse investigation, did not seem to be the world of the frontline street level bureaucrats. Rather their *weltanschauung* was one of processing assessments and care plans. That processing however was not stripped of context, values and assumptions about old age and abuse that bear on decision-making when considering potential abuse. These themes thread through the next section, which describes findings about the culture and organisation of the Authority.

## *Culture and organisation*

Organisational culture can be a slippery and ill-operationalised concept. The outputs of global business schools and corporate consultancies like McKinsey, permeated UK public sector policymaking and governance in the last decades of the twentieth century. That seepage introduced 'culture' into organisational discourse, described at length — but never defined — in the 1980s management best seller '*In Search of Excellence*' (Peters and Waterman 1982), or depicted as organisationally manifest in rituals, routines, stories, symbols, power, structure and control (Johnson and Scholes 1999). Somewhat closer to the constructivist thrust of this research is the description of culture offered by Gareth Morgan (1997:138):

> Shared values, shared beliefs, shared meaning, shared understanding and shared sense making are all different ways of describing culture. In talking about culture we are really talking about a process of reality construction that allows people to see and understand particular events, actions, objects, utterances, or situations in distinctive ways.

Taken thus, the culture of the Authority that emerged from this research was one characterised broadly by homogeneity (between managers and front line), expressed in shared stories and messages, shared ideologies about care of older people, and shared recognition of factors constraining the nature, pace or direction of development. An organisational culture of expectation that poor practice would and should be challenged by the frontline was less embedded. Findings on this, and unifying features of culture, are described in what follows. This section is in three parts: cultural cohesiveness; organisational reflexivity; and challenges to poor practice.

### Cultural cohesiveness

The small size (in terms of overall budget, population served and staff numbers) of the Authority was described by managers and frontline as a reality to be managed, which required creativity, resourcefulness and the capacity to make small bits of cash go that extra bit further[39]. A cultural message, which both Authority managers and

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[39] In retrospect, this could have been probed more in the fieldwork, to get examples of the creative use of small pots of cash used to support older people at risk of abuse. This was a good example of the

the frontline recognised, was that social workers and team managers should draw on expertise and knowledge within and across adult services, as there were no in-house specialist posts or units, a situation summed up by one manager as:

> It's you or it's nobody, cock, you know, I'm sorry but it's you or nobody. There's no vulnerable adult team, no reviewing team, no intake team. It's you!

*Authority manager*

Rather than simply making a virtue out of necessity, this lack of cash had become part of a unifying *esprit de corps* that shaped how people described the culture of the Authority, and how they worked together. With cash not available for specialist teams and posts, the pitfalls of specialisation were avoided (for example, segmenting expertise away from the core, or transaction costs of getting discrete parts of the service system working together):

> It puts a lot of pressure on social workers but I do genuinely believe that we've got a staff team who may move slowly but they *all* (respondent emphasis) move because there isn't anything out there that's additional. The more specialised people you get it (expertise) stays with those people, whereas protection of vulnerable adults work has to be like the writing in the rock.

*Authority manager*

The general supportiveness of the culture was recognised by teams, and the message from managers that they should 'buddy up' with experienced colleagues and draw on each other's knowledge was a familiar one at the frontline. Similarly, frontline workers felt supported by a culture that encouraged discussion and tolerated the 'messiness' of decision-making in situations where facts may be few, but anxiety levels acute. One manager, who had worked in the Authority for some years prior to promotion, commented:

> I've always found the culture supportive in decisions that you've made, and if you can demonstrate you've thought about things, and you've done what you can and you've recorded what you've done, that's supported in the culture.

*Authority manager*

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researcher's *post hoc* waking up to detail in an account, after many readings of a transcript, and at a final stage of writing up the research.

Maintaining organisational cohesiveness and consistency of message was also embedded in the delivery of training to frontline teams. Two job-sharing Authority managers provided the two-day professional training for Authority staff, police, health and voluntary sector partners. This arrangement had arisen opportunistically: as well as their Authority posts, both managers worked part time as independent trainers and had tendered for this work. Again, this was used consciously and proactively by managers to develop consistency of practice and message, and to address practice issues in training, thus looping practice learning back into organisational and staff development. Both managers believed strongly that training units, divorced from operational issues, trained staff "to the guidance" rather than the reality of multi-disciplinary practice, and "how you learn to work together with people who think very, very differently" (Authority manager).

## Organisational reflexivity

The policy thrust of care for older people has been that of helping people stay at home rather than placement in residential care. Although often spoken of in conversations with social workers as a policy that originated in the NHSCC Act 1990, maintaining older people at home has a much longer history in policy intention[40] and service design for older people. Frontline staff in the Authority spoke of the priority to maintain people at home. Numbers of older people living in care homes in the Authority were dropping "which generally we would see as a good thing" (Authority manager). Another manager summed up the Authority's approach to service and care planning: "we've always felt the last resort is a nursing home. It's not where we feel older people should be living".

This ideological hold was being questioned by Authority managers during the time this research was being done. The large scale institutional abuse investigation catalysed reflection on this approach, described by one manager as "residential and nursing care bad, community good", or the belief that "there will be a day when

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[40] Means and Smith (1998:319) reminded us of the following, written in 1955: "The importance of enabling older people to go on living in their own home where they most wish to be...is now generally recognised". (Ministry of Health 1955:38) *Report of the Ministry of Health for year ended 31st December 1954. Cmnd 9566.* London: HMSO.

there's no such thing as residential and nursing care, we don't need it if we were good enough at community care". The questioning of *why* and *how come* this home (and others) provided such a dismal quality of life for older people, led to critical reflection of *what*, systemically, might be critical factors. The established imperative of maintaining every old person at home was questioned by one manager: "I think we all know there are times when that type of communal living is ... well first of all it's necessary to make it work but also actually it is in some people's interests ..." How realistic, and ethical, this ideological hegemony remains in light of projected increases in numbers of older, frail, highly dependent people was not raised by respondents in this research.

The large-scale abuse investigation led to questioning the amount of cash paid for care home places (considered further in the following section), and of gaps in regulatory, contracting and review systems. How far these gaps amounted to 'systemic not-seeing' the day-to-day lived experience of people living in this care home led to some searching questions:

> All this activity that goes on often doesn't seem to get to the heart of how people are living and being cared for. (When a report) throws up quite serious concerns about the place, we think well hang on a minute, we've had contracts with individual people there for a long time. We've had bits of POVA cropping up now and again, why don't we have a full picture of what its like to live in a place like that where the people are subject to abuse and so on?
>
> *Authority manager*

This questioning and reflexivity was, to a certain extent, a feature of the teams. One team held periodic reflective practice sessions, where cases were discussed. An Adult Services-wide 'practice forum' (a multi-agency forum for managers and frontline staff to discuss adult protection practice) was held periodically. The event observed for this research seemed less focused on practice development or reflective practice, and more like a standard meeting where agenda items from the AAPC were reported back to those present (mainly team managers or equivalent from agencies; no social workers were present). How far this patterned 'meeting behaviour' was the institutionalised culture of this forum was not clear. One item (which had been discussed the week before at the AAPC) was whether it would be a good idea to have 'case audits', or case discussions. Responses were guarded. My research notes recorded one team manager saying it might be helpful to 'gain from another pair of

eyes' but that the work would be 'an additional burden'; another that 'we need to debrief, but there's the capacity issue'. The day-to-day pressures on frontline time and resources were palpable and, even though the proposal met with murmurs of agreement, no definite decision was made about if and how to progress it.

This apparent reluctance to critique each others' practice, here through case audits, was replicated in the dearth of examples of where street level bureaucrats or managers overtly challenged each other's practice. This could of course have been a feature of the supportive culture people described, where conversations about 'what to do' with a case may have involved challenge to proposed courses of action, or ways a case was being 'read'. Constructive, concerted critiquing may also have taken place in supervision[41]. However, examples of routine (that is, built-in to everyday practice) professional challenge to colleagues in or outside social services, did not feature strongly. Neither was challenging poor practice in some care homes concerted or direct, and it is these findings I turn to next.

## Challenging poor practice

The large-scale investigation had, as noted, raised questions about why the review and regulatory systems had not picked up earlier on the poor quality of life for people living there and, more tellingly – why the 'known' poor quality of the home had not been questioned, challenged or confronted by social workers and other professionals going in there. This raised the issue of how far the organisational culture — as in Gareth Morgan's "shared process of reality construction that allows people to see and understand particular events, actions, objects, utterances, or situations in distinctive ways" quoted earlier — encouraged or discouraged challenge to potentially abusive practices.

Responses suggested challenge to poor practice was inconsistent and uncertain. While action followed referrals of potential abuse (these of course would be made by others, and referrals would have to be actioned), poor practice like a care assistant

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[41] It is this writer's experience, from designing and delivering scores of supervision programmes to social services staff and mentoring individuals in many local authorities, that supervisions sessions are mainly taken up with workload allocation and management. Professional development and routine critical questioning of practice frequently fall away because of time pressures people face.

speaking roughly to an older person, might escape challenge, although teams said they spoke about this among themselves. The question 'are social workers having a quiet word with the home or challenging poor practice if they witness disrespectful or undignified care?' was asked many times during the research. One manager commented:

> Like with everything in management you want to get to a consistent position and we are not at that I would say. There are some people with the confidence to (challenge) and we've seen that recently. Some staff are very good at going in and gently saying that. Other staff say it in a way that isn't productive, or just don't have the courage to say it.

*Authority manager*

The same manager was unsure that staff would 'read' some situations as requiring challenge, for example: "if people are left just sitting in a chair for four or five hours a day without any interaction at all, would people confront that?"

Another was more explicit in saying this was behaviour managers expected as an organisational requirement:

> I can see the staff out there who are doing it (challenge) and I can see the others that aren't and those are the ones we have got to say (stay or go). Unless they can come up to the mark in terms of really...holding people to account, unless they can do that and have support to do that then we can't really manage this profession with those people.

*Authority manager*

The organisational expectation and 'permission' to challenge was recognised by social workers — "you are encouraged to challenge the quality of care and you will be supported in that and the organisation will be very pleased you've done that". Challenging poor practice, though, requires confidence as well as practice. Within the multidisciplinary framework of the adult protection procedures, a manager who also ran the multidisciplinary training, found professionally assertive social work to be less than strong :

> One of the things we're not good at is we lose the social work perspective sometimes in the (POVA) process. The bit I don't think we're good at, whilst we're in that process of strategy meetings and potentially an investigation, (is) enabling the social worker to work alongside the (alleged victim) more to support them, to

> make sure they're involved. I don't think we release the (social work) resource to do that well enough.
>
> *Authority manager*

This professional 'uncertainty' – whether in actively engaging in self reflection, challenging poor practice or taking a strong professional role in the adult protection process – seemed to turn, in part, on the nature of the day to day working life of social workers. Social workers who had been in the profession for many years[42], and who had chosen to stay in frontline practice, mostly spoke confidently about using their role, experience and expertise in opaque or uncertain situations.

In one example, a social worker on duty described being called into a potential abuse alert in a healthcare setting. An elderly man, with fluctuating mental capacity, had been admitted to hospital, and when examined was found to have pressure sores. Ward staff had spoken with his wife, the main carer, implying that her care was inadequate, and that this may be referred as an abuse alert. The woman, angered, threatened to discharge her husband to whom she was "devoted, loving". The social worker described the situation as "inflamed" and, as this was a duty call, the imperative was to assess by "observation, listening, looking, and being very quick". The social worker talked with the woman, away from the ward to "lower the pressure", saying "I've come into this very fraught situation, is that how you're sensing it? ... I need to start where you are". The social worker mediated between the woman and ward staff over the following days to stabilise the situation, and then to set up shared care of the man by his wife and nurses in his last year of life. There was no evidence of abuse, and the case was care managed.

Another experienced social worker, whose career had started in work with older people before joining learning disability services, spoke of

> (my) shock to come back (to work with older people) ... to find ... although social work practice with older people and the range of service provision (has) improved beyond recognition ... when we hit the residential and nursing home sector, it's like nothing has changed, notwithstanding the Care Standards Act ... They've not resolved the issue between 'is this a home or a hospital ward'?

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[42] These were few in number as the career trajectory in social care typically promotes people to management rather than advanced practice posts.

*Social worker*

This social worker compared being in hospital to some nursing homes:

> We all do go into hospital for a reason, we all suffer the institution because we've got a short-term medical need. We allow ourselves to be processed medically and you put up with all the indignities because the sole objective of you being there is ... you'll get out. But that kind of clinical environment, it can't replace life. That can't be how your life is. A lot of nursing homes in particular are all very much modelled on that ...

*Social worker*

This social worker was critical of the weekly rates paid for care home placements, as were others. Asked if awareness of the quality of some care homes was factored into decision-making and care planning, the social worker was equivocal:

> I hope it wouldn't affect my judgment if I thought the consequence ... was this person is going to end up in a care home, so (therefore) I won't do it.

*Social worker*

The confidence some more experienced social workers had to manage and work with difficult care situations did not however translate into their direct challenge of quality, services or others' practice more widely. There were few examples given of street level bureaucrats or managers 'challenging' each other, or other agencies; for example, in questioning the time it took to provide services, the quality of services, or the effectiveness of services. Some street level bureaucrats seemed less sure of what could, should or must be challenged; some seemed overtaken by the volume of work they had to deal with. Late starts to meetings in social services are nothing new: what was striking was how focused people were on finishing a task before starting a focus group for example, and how quickly they returned to their work after the group had concluded. How far the nature and volume of social work with older people diminishes professional confidence, resulting in 'looking but not seeing' or uncertainty about challenging poor practice, is considered in the next section. This discusses dilemmas of demand and resource management in the Authority.

## *Dilemmas of resources*

There can be little doubt that the provision of social services to older people is perceived as one of managing supply and demand. A policy narrative of the times is that of an ageing (for which read 'non-productive') population, placing increasing (sometimes exponentially, depending on the policy source) demands on health and social care services, requiring the use of ever tighter eligibility criteria, and continued reliance on unpaid female labour to shore up care provision and manage the cracks and gaps in service provision.

In this, little has changed in the policy and provision direction of travel that predated the passing of the National Assistance Act and the establishment of the NHS in 1948. In their social history of the development of the welfare state from the Poor Law to community care, Means and Smith (1998) identified the extended taproots of many current dilemmas in service provision for older people. These include rationing of domiciliary care (which only became mandatory for local authorities to provide in 1968), long standing cost-shunting between the NHS and local authorities about who pays for continuing health care needs, and an historical failure to establish older people as a priority for health or social care. The findings from this research on how resource dilemmas are managed at the frontline and by Authority managers illustrate how this broader historical, political and social backcloth is played out in real time by real people in very real situations of need.

This section summarises findings on dilemmas of resources in two parts: the quality dilemma and the shortfall dilemma. The cultural homogeneity reported on in the last section is also reflected here, notably in the absorption by frontline workers of managerialist realities of cost containment and resource management.

### The quality dilemma

Minutes of AAPC meetings and other Authority documentation were dominated by concerns about the quality of care of older people in hospitals and care homes, and with the non-attendance of health Trust representatives.

Analysis of AAPC minutes done for this research found every meeting since the AAPC's inception in 2006 had been taken up with both these concerns. The NHS Trust had not nominated an operational manager to be a member of the AAPC, even

though AAPC Terms of Reference required this. Two different nurses had attended a minority of AAPC meetings between them; no Trust representation was made to the others. The minutes for December 2006 noted an action to "clarify mechanisms in the Trust for securing attendance". The following meeting in March 2007 noted no response had been received. My research notes of the AAPC I observed — where no one was present from either the Local Health Board (LHB) or NHS Trust — recorded 'health Trust not really part of this (adult protection process) at all. How does this affect teams and inter-agency work at the frontline? How does it affect decision-making about action to protect an elder from abuse in healthcare settings?'.

Social workers illustrated these issues in a number of ways. Securing a health check for an older person where there were abuse concerns could be difficult according to one social worker: "sometimes I find people waver over things and don't consider (the older person) fully health wise". This 'category overshadowing' of age in health care accompanied casually dismissive treatment in care homes where staff treated a person roughly or where older people in wheelchairs were "trundled round corridors without foot rests" (social worker). In hospitals, discharge pressures were said to 'evaporate' if abuse concerns arose, and the older person would be moved to a peripheral hospital pending investigation of the allegations. A hospital social worker believed this posed greater risk, that of developing a hospital-acquired infection.

The absence of basic care in some healthcare settings was commented on frequently. One social worker spoke sardonically of waiting for the NHS to re-badge relatives as "partners in care", as relatives had to provide so much basic care

> just to ensure their loved ones get access to adequate hydration during the day. It's about glasses and water jugs being close enough (to the person). I had a manager of a home say to me last week 'we don't leave water jugs out because there can be an accident, they can always ask us if they want a drink'.
>
> *Social worker*

This social worker saw care homes as having become "the extension of the long stay geriatric wards", affected by the expectations professionals and families had of such services:

> I experienced a really good home in the midlands recently. I was ... waxing lyrical to myself about it and I thought about it again ... why am I waxing lyrical about it? They're just providing the sort of care you'd expect to be provided for someone.

*Social worker*

Frontline staff and managers were asked about the extent to which known poor quality of some services became factored into decision-making. The way in which this seemed to happen was insidious, with one social worker describing the self-questioning: "should this person be here? Or should they be somewhere else? At some level you're factoring that in, but I am aware it's a dangerous thought process". This social worker summed up how the calibration of least worst scenarios was played out when considering the poor care a man received in his own home: "the problem is that whatever criticisms you might want to make of his care, and there are criticisms, it's probably significantly higher than your average nursing home". Thinking of one, the same worker continued:

> ... that atmosphere and that attitude...most people who've never been in a nursing home would just be completely shocked by it. The danger for us is that we (get used to it).

*Social worker*

The question 'how far is known poor quality care influencing your planning for older people' was an uneasy one to answer. An Authority manager speculated:

> I don't think for a minute social workers would actually walk away from a situation they thought was abusive but I do think if you said to social workers 'are you content with where people are placed, is this the sort of quality of care you'd want', then probably the answer is no. I suspect what happens really with the (home under investigation) of this world is that incrementally you know people adjust their standards ... and you have to make sure their standards stay above what's acceptable.

The dilemma however, was palpable:

> You've got somebody broken down at home, the carer can't possibly cope anymore, you're going to make a placement, it meets regulatory standards, it's acceptable, but well ... That's a very real world for people.

This manager continued:

> At what point can we say we're meeting our statutory duty by being able to offer homes and at what point is the reality becoming that if you haven't got a top-up you're going to move further afield? Those are just horrible ethical dilemmas that we live with and we keep saying, well are we just about on the side of (laughs) statutory compliance or not ...

Financial limitations were not viewed as the main reason why the quality of care home provision sometimes sank so low:

> We tend to pay above inflationary increases because we recognise that we're scraping the bottom of the realistic pay scale ... this year we're hoping to put a 4 per cent increase in. So the homes often say you're not paying us enough to provide high quality care and (while) there is an element of truth to that, it's not quite that simple.
>
> *Authority manager*

In these quotes we see the stark impact of these dilemmas on older people: the recognition of examples of poor quality care, and an 'incremental' adjustment of standards of acceptability (downwards), counterposed with the view that 'it's not quite that simple' to suggest standards were low because of inadequate cash. A deeper questioning of the *context* of this dilemma — if quality is low and it's not all about cash, why do older people have to live their final days like this? — was less evident. The implications of this are discussed further in the following chapter.

These dilemmas related to the quality of some existing provision for older people. Street level bureaucrats and their managers also grappled with the related dilemmas of service shortfalls, ie, where services were not in place or at sufficient volume, to meet identified need.

### The shortfall dilemma

Dementia services and extra care housing were known to be service shortfalls, as was insufficiency of support to victims of abuse. The role of the Authority in shaping the market, and in improving the quality of failing provision was unclear, particularly because of the issues the large-scale abuse investigation had highlighted:

> (There's been) some debate about what's commissioning's role is in helping that organisation to reprovide ... and that's not necessarily their role, they tell the service what they want. It's not their role to get in there and help the provider learn how to do it. So ... how do things change? There's a gap there between what we would like to be in place in terms of provision and the ability the local authority has to aid that process. I don't know how we leap across that particular gap when you've got an area like (Authority) where ... it's very difficult even to encourage providers in.
>
> *Authority manager*

Somewhat more within its gift, was the time people working in the Authority had to spend on adult protection work generally, or with older people particularly. This of course is not a result of chance, but an outcome of macro policies and decision-making that privilege spending time or cash on work with one group over another. Authority managers spoke of their span of control as precluding long-term focus on social services to older people, and of the dilemma this posed, for example:

> It feels a constraint in terms of the time people like me and (strategic coordinator) can give to this work ... we'd be much more interested in creating the conditions in which people are properly looked after.

The same manager recognised the importance of giving focus to older people's services and elder abuse: "I suppose you can add all the usual money and things like that but I think ... strategically it's about giving it attention".

For street level bureaucrats, the care management process itself limited the time and nature of contact social workers had with an older person; as an Authority manager commented: "they're not with people long enough to necessarily get the full picture, but our process doesn't enable people to be in there for long enough". The shared (between manager and frontline) sense of pressure on time also extended to frontline staff being very aware of the financial implications of decision-making. A social worker in a focus group summed up the financial dilemmas some families face when an older person lives in a care home:

> (Authority) have about £370 as the base rate for residential care. Some costs £450-500 which means a top-up. Very few families can afford that, especially if you're talking about someone in their nineties. They could easily have pensioner children ... top-ups are a very difficult subject. You say you're not supposed to use your mum's money for this but we know they do in cases, because what's the alternative? It does have a bearing doesn't it? (murmurs of agreement).
>
> *Social worker*

Frontline staff had, it seems, fully absorbed managerialism, and some talked of their concerns about the amount of time the adult protection process could take, or the financial impacts of suspension from duty if an allegation had been made against a carer. One team particularly were at pains to re-check information when an alert was raised, before calling a strategy meeting. An example was given of going back to a service user who had respite care in a residential establishment:

> He came in on an assessment and after about two or three weeks he made an allegation against a member of staff ... we had the paperwork come through from the officer in charge and the first thing we did before going into the strategy (meeting) ... and I know him well ... we interviewed him first to make sure that he was clear that he felt these allegations were true. It's quite a hard discussion we had with him because again some of his behaviour was quite bizarre. We interviewed him twice because of the consequences of what he was saying. At (that) stage his wife and daughter were on holiday. They came back and we sat down with them all together to see if they wished to pursue this and they were adamant they wanted to do this.
>
> *Team manager*

This team manager said this was done because of the seriousness of the allegation and the potential of a carer being suspended whilst an investigation were carried out. The practice therefore appeared to arise in part from a desire to protect resources and to avoid a carer being unnecessarily suspended. The dubiousness of the practice was twofold. First, a complainant and their family, when questioned *twice* by professionals about an allegation before it was referred into the adult protection framework might at the very least speculate about the seriousness with which their concerns were being taken, or whether those working in the service systems were there to meet the service user's interests or their own. Second, the team manager described his questioning of the complainant as 'evidence' gathering. 'Evidence' was what any investigation invoked under the procedures was intended to gather: procedures were clear that evidence should not be contaminated or people repeatedly interviewed or questioned before an investigation was carried out. While this practice seemed to be localised to one team, it exemplified a primacy of professional and service needs relative to the service user (*"we interviewed him twice because of the consequences of what he was saying"*), and the privileging of efficiency, time and cost over the rights of the older person, who in this case had raised the alert himself. This will be considered in the final section of this chapter. Before that though, the next section considers dilemmas in relation to care of an older person.

## *Dilemmas of care*

The sub-title of Lipsky's *Street-Level Bureaucracy* was 'dilemmas of the individual in public services', meaning the individual public sector worker rather than user of the service. While Lipsky included social (or welfare) workers within the scope of his street level bureaucracy thesis, he was not primarily concerned with that sector of the workforce. Findings from this research highlighted the diffused and complex nature of dilemmas social workers faced when dealing with concerns about older people. These 'dilemmas of care' have been collapsed here into three types: the capacity-choice dilemma; the family care dilemma; and the protection dilemma.

### The capacity-choice dilemma

Even if the vignettes (which were used twice) had not included scenarios involving issues of the mental capacity of the older person, the 'capacity-choice' dilemma pervaded frontline accounts of the factors influencing their implementation of adult protection procedures. One vignette, for example, concerned threats to a 78-year-old woman made by her son. The vignette immediately raised the issue of the mother's mental capacity to decide whether to accept her son into her home:

> Critical here I suppose is Mrs Longley herself and her capacity to make informed choices around the decision making around access of her son. For me the issue is whether she is making informed choices about that and what is she weighing in her decision-making ... and therefore what should our response to that be in terms of fettering that discretion that she clearly has.

*Team manager*

Such dilemmas seemed to be portrayed as 'either/or' — either the person had the capacity to make a particular decision, in which case they could choose what to do, or, they lacked capacity and protection arrangements would be instigated. The decisions and 'choices' people made sometimes led to social workers expressing exasperation and bewilderment considering the life choices people make; 'why would you *do* that?' was a weary refrain from one team manager. Nonetheless, considerations of mental capacity and choice featured large in decision-making: if people were deemed to possess the former, they were permitted the latter. Consideration of proactive work with a service user on risk management, their understanding of potential risks and ways to manage these, seemed to feature less.

Similarly, the implications of either/or thinking for those who lacked capacity seemed to be unexplored. If a person with dementia lived in a care home of doubtful quality, what 'choices' would be advocated for them to promote their presumed 'choice' — human right — to be cared for in a dignified and caring way?

## The family care dilemma

The international definition of social work is:

> The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

*(International Federation of Social Workers 2000)*

'Problem solving in human relationships' and intervention 'at the points where people meet their environments' posed particular dilemmas for social workers where there were known concerns about an older person. These 'family care dilemmas' were often located in family dynamics and family structures that pre-existed concerns about care, potential abuse or neglect. One complex situation concerned the quality of care given by the second husband of a woman with children from her first marriage. The adult children were concerned that this caregiving caused their mother to suffer unnecessarily and deprived her of dignity; they also feared their step-father would stop them visiting their mother if they were too vocal in their concerns, or refuse social services and social work involvement. Other agencies shared concerns about the quality of care the woman received from her husband. The management of these dilemmas by the social worker and through the care plan was far from mechanistic care management box ticking. Rather, the team as a whole had discussed the strategy to meet the needs of the woman and her carer. An experienced male social worker was the care manager who appeared to have adopted a 'straight-talking, man-to-man' relationship with the carer. The goal was to keep 'the door open' so that acceptable levels of care could be monitored by those going in, and regular contact was maintained with the family. This was care planning of some subtlety, drawing on the care and control elements of the social work task, and which had as a core feature social work intervention in the family dynamics, as well as service provision.

Where one older person was caring for another with significant health and social care needs, sheer exhaustion and, not infrequently, a poor relationship, could lead to fragile care situations reaching complete collapse. One partner may want the other admitted to a care home, one may refuse to have the other return home after a hospital admission. One team manager summed up this dilemma when dealing with a referral about unexplained bruising of an 85 year old woman with severe rheumatoid arthritis cared for by her 93 year old husband: "you go from 'this is abuse and is being done deliberately' to hang on a moment, to care for someone who's elderly is quite hard work".

Social workers were often at the core of professional decision-making when those involved in care-giving (paid or unpaid family care) disagreed about the sufficiency or adequacy of care an older person received. Again, the complexity of family dynamics was exposed when opened up to the glare of professional assessments and intervention. An older woman described as very passive and acquiescent was cared for by her son, considered by paid carers to be controlling and restrictive in the amount of choice he gave his mother over the type of food she ate. He, for his part, found the carers intrusive, untidy and careless in their treatment of his home when attending his mother. Again this was a situation batted around in 'is it / isn't it abuse?' conversations. The social worker construed their role as monitoring the quality and adequacy of care the woman received. The case was managed outside adult protection processes.

## The protection dilemma

A key factor bearing on implementation of the adult protection procedures by frontline workers was, as we have seen, their awareness of abuse. Taken up a level, as concerns about poor care or possible abuse came to light, they grappled with the 'protection dilemma' — at what point could or should they implement adult protection procedures (thus involving other agencies), in situations where an older person opposed this.

Alleged theft of money was one example. A social worker described a dilemma she had encountered more than once with different service users:

> The person said that money had gone missing, (taken) by a carer they liked very much. We held a strategy meeting, and decided the actions that people should take

> and I went down to speak to the person (service user) and basically he...denied it all even though he disclosed. But you couldn't take it any further then because he wouldn't take it any further. He said he found the money and he wanted the carer back, because the carer was suspended in the meantime, and he wasn't happy about that because he liked the carer.

*Social worker*

The failing physical health of an older person, and the need for high levels of care, could pose intractable protection dilemmas, particularly when concerns intersected with uncertainties about the older person's mental capacity. One social worker described the dilemma of a woman who was bedridden, had fluctuating mental capacity and deteriorating physical health, and who lived alone supported by carers for several hours a day. The woman developed pressure sores, her bed was often soiled, and it was difficult to secure a supply of appropriate incontinence pads for her. Professionals wanted to arrange hospital admission to build up her physical health, but she refused. Her son, who lived in another county, said he had promised his mother she would always be able to stay in her own home:

> We used to criticise the son but whenever you actually spoke to him, he was always extremely reasonable in what he said. His mother didn't like being in hospital, she was very unhappy, she screamed and she was very upset and tearful ... It didn't appear to be what she wanted at the end of the day, but we weren't sure about the capacity. (When she was going to hospital) she would be screaming and crying and shouting and kicking at being led out of the house to the hospital ... so you could argue that she did know where she was and that she didn't want to leave her house.

*Social worker*

A countervailing factor for this practitioner was their concern about standards of hospital care and cleanliness, and whether the older person would be adequately fed and hydrated whilst they were there. It seemed that this, as well as the extremely strongly expressed feelings of the older person, resulted in the woman being cared for by paid carers until her death, at home. The reasons why 21st century UK health care could not provide suitable incontinence pads apparently passed unquestioned, another example of tacit acceptance by default of very low standards for old, sick and frail people. Such 'dilemmas of care' were managed in a variety of ways, whether within or outside adult protection procedures. In this, social workers exercised professional judgement and discretion. These are considered in the final

section of this chapter, which discusses findings on power, discretion and the use of adult protection procedures .

## *Power, discretion and procedures*

Professional discretion in social work has been said, as we have seen, to have become lost to the technocratic box-ticking of care management. The findings of this research paint a more subtle picture of how professional power and discretion in social work to protect older people from abuse are exercised in this Authority. Rather than a simplistic 'either/or', where discretion is either present or absent in professional decision-making, social workers demonstrated a preference for, and use of, structured procedures in their work to protect vulnerable elders, *and* exercise of discretion and professional power in *how*, *when* and *why* they used the adult protection framework. This section considers findings on how adult protection procedures were used, and how discretion was or was not exercised.

### The value of procedures

Both managers and frontline staff were very positive about their adult protection procedures. There were two main reasons for this. Firstly, people thought the procedures were clear and comprehensive: "(it) is a very, very good set of guidance. It's very straightforward. The decision-making is very, very clear" (Authority manager); or "I'm very fond of them. We always say it's worth reading because it's all in there in terms of everything you ever need" (Authority manager); and a social worker "it makes it clearer what you have to do".

Secondly, the clarity provided a structure and an efficient process within which agencies could jointly decide on action:

> To do the information sharing at the professional level (the procedures) actually speeds things up. You are able to find out a lot quite quickly that would be missed if you were doing it in your own little silo.
>
> *Authority manager*

This structured approach contrasted to case handling prior to agreement of the procedures, which was "too mushy. You couldn't get hold of it. We used to think what shall we do? Now you can do something with it, and you can bring other people in to help you in that, whereas before you were on your own" (Authority manager). Frontline staff found the structured process helped practice and decision-making:

> I like the guidance. I'm like Mrs Process, I like a process to follow, I like 'stages 1, 2, 3, 4'. I know what we've got to do and know there's backup so I feel very

> comfortable about the whole thing. We're a very supportive team ... it just builds your confidence.

*Social worker*

The documented process, where decisions and reasons had to be recorded for actions taken or not taken, was seen as an aid to professional practice, rather than a threat to professional autonomy. *Not* proceeding to an investigation after an alert was signed off on documentation by a DSO, "which is very good. If you're ending this (POVA process) here, why? What's the evidence?" (Social worker).

Not being professionally isolated was another gain social workers identified from having the adult protection framework. For example,

> You don't have to make a decision on your own about something that's quite serious sometimes. I don't think it hinders you really. It's reassuring to sit in a team of people and make a big decision and not have that sitting on your shoulders solely.

*Social worker*

Team managers agreed that collective multi-disciplinary decision-making meant "you're less likely as a social worker (to be in a situation) where you're on your own with a case". It also made timeframes explicit for discrete parts of the process. A strategy meeting had to be held, for example, within three working days of an alert being raised, if initial information gathering indicated adult protection procedures should be instigated. Far from being viewed as a bureaucratic impediment to professional autonomy, this was seen to offer a basis for planning: "you know there's going to be action within so many days. I find it really helpful" (Social worker). Similarly, the structure — a framework within which professional opinions were offered and collective decisions reached — provided space for the exercise of professional discretion: "I find that it does actually free you up because it holds you. I find having a structure like that frees you up" (social worker).

Bringing professionals together under adult protection arrangements, whilst offering advantages of multi-agency work, also had disadvantages. These were described by frontline workers as perceptions, attitudes and ways of working that were divergent, different or difficult for social workers. One social worker described a strategy meeting that had agreed a service user should be moved from a care home:

> The conflict comes from the professionals. You know the police have a very set view of what they need to be doing, and registration and inspection (*sic*). From my

> point of view they don't take into account anything other than their procedures. They don't take into account the person's reactions or whether there is anywhere to move that person to, that's appropriate for them. That's not on their (the regulators) mind, whereas with social work you have to think about those things and I think that causes conflict between professionals rather than the actual procedures.
>
> *Social worker*

This suggested a potential diminution of the professional social work voice, not because of the procedures *per se*, but rather because of the dynamics of inter-professional decision-making. The blocks and difficulties of inter-professional working have been well documented, and include poor communication, 'language' differences between professionals, conflicting ideological differences and role confusions (Cameron *et al* 2000; Sullivan and Skelcher 2002). Inter-agency procedures, of course, do not *ipso facto* overcome these frustrations, although it is at least possible that a strongly assertive professional social work voice could prevail over inappropriate decision-making.

## Professional autonomy and the procedures

Professional autonomy was more apparent within the Authority in decisions about whether or not to use the adult protection procedures in the first place. What was clear from managers and frontline staff was the cultural 'permission' to use, or not use, the procedures to meet the needs of the older person, rather than automatically becoming enmeshed in a procedural process with a momentum of its own. Frontline staff and managers spoke of the various ways in which potentially risky situations of potential abuse would be managed, for example, through risk management processes outside adult protection, or through care management.

Similarly, cases were spoken of as 'going into and coming out of POVA'; as one social worker commented "I'm very clear you don't have to stay in POVA, you can come out as often as you want". The message that procedures in and of themselves protected no one was understood: "Even if someone is being investigated under POVA ... it doesn't mean that person is actually going to be protected or the situation will change, because there might not be the resources, it doesn't create or magic extra resources" (social worker).

## Discretion

The exercise of discretion in the way the procedures were used was exemplified by one team's interpretation of the information gathering stage (described earlier in this chapter). The procedures stated information gathering involved "initial consultations with others as appropriate. The purpose is for the DSO to pool available information; decide the appropriate course of action; and on the basis of this decide if a strategy meeting should be called" (Internal Authority adult protection policy).

In one team, as we have seen, speaking to the older person prior to a strategy meeting and after an alert had been raised, was not uncommon. In another case dealt with by this team, an older person disclosed information to a home manager that led to adult protection procedures being used and the suspension of the carer. The team manager asked the social worker to speak to the service user "just to assess their understanding of it all and get a picture of them really" (social worker). As we have noted, the risk with this practice was that it potentially complicated an investigation, if a person found themselves being questioned repeatedly (even if that was not intended), or they felt disbelieved. The team manager was adamant that

> I'm not going in there as an investigating officer. I'm going in there just making sure what they (the older person) are saying. I'm not asking anything else OK? All we do is go out. We don't investigate. I'm not saying who did it. All I'm saying is can you just tell me what happened. It's being 100 per cent clear what they're saying. We're getting the bare facts. There's a big difference between 'I have been abused' and 'I have been handled inappropriately getting out of the chair'.
>
> *Team manager*

Whether this interpretation of the procedures and use of discretion was the case in other teams was uncertain: it appeared to be the practice of the one team. Managers were clear in the messages they said staff and team managers had:

> We advise them (staff) not to use discretion in reporting to their line manager. We say ... 'it's your responsibility, it's your duty' quite clearly to report under these (procedures), so we don't ask them to use discretion. Then it's up to the line manager to decide whether they're going to take it into POVA or not. And I guess there's some leeway there because that's where that decision making is ... is it (poor) practice, is it abuse?
>
> *Authority manager*

Other team managers felt the Authority encouraged them to "undertake our DSO duties with a certain amount of autonomy". A manager commented:

> I think it's a culture in which discretion can be exercised. I know the procedures say you refer to a senior manager, that would be via a discussion so it's not that you refer to senior management for a decision. You'll discuss the decision-making with your manager and so long as that is sound — they will say have you considered this? — but it wouldn't be that they would make the decisions. DSOs would be expected to be the decision makers, who would be using judgement.

*Authority manager*

This expectation that professional judgement could and should be exercised in considering how to manage a case was recognised by others:

> As long as people are made to justify how they use their discretion ... we all take responsibility for our own actions, so if I miss out (a stage of the procedures) and there's a total mess-up because of that, however good my rationalisation was for doing it, then I'm prepared to take responsibility.

*Social worker*

Discretion was also exercised — and recognised as such —in the way concerns or alerts were described, portrayed and presented in the discussion between the DSO and social worker:

> I had to generate pages and pages ... in order to put the DSO in a position where he wouldn't just be saying 'well I back your judgement', (but) so he could actually come to that decision himself.

*Social worker*

This power to 'name', shape and configure a case in the way concerns were described and presented was not recognised as 'power' but as 'responsibility'. Despite many examples and descriptions of how professional autonomy and power were exercised within the adult protection procedural framework, these seemed all to be located in decision-making in relation to an individual older person. In other words, the exercise of power was individualised, both to the service user, or the social worker or team manager. The macro context surrounding the circumstances of these individual situations, for example, poor care homes, poor treatment in hospital, was not an arena where professional leverage was exercised systemically (on the system) or systematically (with focus, structure and organisation). As described earlier in this chapter, overt professional challenge to dubious practice was not

embedded in the practice or culture of the Authority. The wider systems that may themselves have contributed to poor care, eg, cursory reviewing processes, flaccid regulatory or commissioning functions, were not overtly challenged or criticised by the frontline.

Yet the potential for collective professional challenge was, arguably, greater than at any time in recent history of the social work profession. Since 2004, employers and registered social workers have had to comply with the codes of practice for social care workers and social care employers. For social workers this involves, *inter alia*, 'bringing to the attention of your employer or the appropriate authority resource or operational difficulties that might get in the way of the delivery of safe care' (Care Council for Wales 2002). Employers have a mirror responsibility to have in place systems for such reporting. Whistleblowing policies have been in place since implementation of the Public Interest Disclosure Act 1998. Yet there were few examples of collective professional power being exercised to challenge the macro context of health and social care provision for older people, and the service systems that spring from it. This chapter therefore ends where it began, in a broader social context that shapes the nature, quality and adequacy of services to older people. In the following chapter, the implications of these findings are discussed in relation to the questions the research set out to address.

# Chapter 6 Discussion

We start this chapter as we did that preceding it, with a recap of the research questions. This study set out to examine if Lipsky's concept of street level bureaucracy, developed in the US during the 1970s, had continuing salience forty years later. Specifically, this research aimed to find out what influenced the implementation of policy by social workers to protect elders from abuse, and to identify the dilemmas they and their team managers faced in doing this. The understandings that agency managers, and social workers and their team managers, brought to bear on the intention and operation of the procedures, and the impact of these on local policy implementation, were additional research foci. The task now is to discuss findings reported in the previous chapter in light of the study's starting point.

To do this, this chapter is in four sections. The first takes an overview of the findings and the research as a whole to review the structure, design and methods of this study. This is followed, secondly, by discussion of key themes emerging from the findings, in light of four aspects of Lipsky's thesis of street level bureaucracy. This section discusses how far Lipsky's framework shines analytical light on the processes involved in policy implementation by social workers to protect older people from abuse in the Authority. Thirdly, the permeation of ageism into care management and service design, structure, and delivery is discussed, as this coalesced many of the factors that bore on street level implementation by social workers of procedures to protect elders. Finally, ethical questions raised by the findings are discussed.

## *The research design revisited*

This was unfunded, unsponsored, one-person research. That in itself brought both constraint and opportunity to the research design and execution. The paucity of resource (time and cash) available for the task was constraining in that only one local authority in the region could be studied. Research access to two or more authorities using the same policy and procedures, would have brought a richness of case comparison to the enterprise and — potentially at least — provided scope for differentiating types and typologies of organisational cultures as determinants of street level policy implementation. This constraint, however, focused a depth of attention on one small Authority, and provided acuity of focus and significant

opportunity for iteration as the fieldwork progressed. Early findings on the lack of challenge by social workers to poor practice, coinciding with a large-scale abuse investigation, were built into subsequent interviews, discussions and groups. The questions the research was asking directly related to events as they unfolded in a real time abuse investigation. Consequently later research interviews with managers tested out tentative themes that had emerged from the interviews and focus groups with street level bureaucrats, as well as the unfolding abuse investigation. Thus the focus on a single small Authority provided enough flexibility to roll with the unfolding picture for the Authority actors, whilst staying directly with the research questions themselves.

Carrying out the research in a small authority allowed access to the relevant managers and people in teams, without sampling decisions becoming necessary. Whether or not to include older people in the study group (described in chapter 4) had been considered carefully during the design phase. It was rejected as unfeasible in a small-scale exploratory project such as this.

Early on in the fieldwork, when it became apparent that social workers either did not 'see' or did not encounter elder abuse very often, a further question emerged about potential factors influencing social workers in their implementation of adult protection process. That was, how often, how easy (*sic*) might it be, or how likely was it, that an older person would intimate (if not fully disclose) abuse to a social worker? Was the perception an older person had of the social worker and their task, of the social worker's awareness of their situation, further influencing factors on implementation? Bergeron (2006), for example, has described the impotence abused older people felt when, to them, a social worker failed to pick up obvious signs of abuse. Finding out from older people about their perceptions of the awareness a social worker may have of domestic abuse, of their views about what judgments a social worker might make or, indeed, if they thought the social worker would have time to listen to them, would add to understanding factors influencing policy implementation by social workers. However, access difficulties in recruiting elders to such a study would have been way beyond any reasonable expectation of what a lone, unfunded researcher could achieve. As it was, the findings showed that street level bureaucrats do not always 'see', and then act on, potentially abusive situations. Research findings discussed in chapter 3, and the UK elder abuse prevalence study

(O'Keefe *et al* 2007), found abused older people were disclosing more than expected — but we don't know what happens *after* they disclose[43]. There are many areas where the voices of older people are vital to our understanding more about elder abuse and how to support people, and some of these are discussed in chapter 7. In this project though, the study group as constituted was fit for purpose as the research was concerned with policy implementation by street level bureaucrats, and it has shown how they do not always 'see' or read situations they encounter as abusive.

Commentary in chapter 4 described why the vignettes were pulled from interviews after being used twice. The conclusion I drew from this was that vignettes may have a role to play where people are asked, intellectually, to identify their beliefs or guiding principles. However, the learning from this research was that their value was limited within this research design; their hypothetical nature simply got in the way of the 'conversation with a purpose' the interviews aimed to create. Decisively pulling them at an early stage minimised what would have been a problem of validity if half the interviews had used them and half had not; and the learning (use the appropriate research tool for the specific purpose) was a useful reminder of elementary research practice.

The following section returns us to our opening discussion in chapter 2, which described elements of Lipsky's concept of street level bureaucracy. The findings of this research are discussed now in light of those elements.

## *Lipsky revisited*

For Lipsky, actual policy determinants (rather than those formally written into the policy script) were the day-to-day realities bearing on street level bureaucrats:

> (t)he decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out.
>
> *(Lipsky 1980:xii, emphasis in original)*

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[43] As we noted in chapter 3, the UK prevalence (O'Keefe *et al* 2007) study did not ask respondents what happened after they disclosed abuse.

Our discussion in chapter 2 about street level bureaucracy considered four influences Lipsky identified that, for him, determined the actual (rather than intended) policy delivered to the public. These were, firstly, the exercise of *discretion* by street level bureaucrats, discretion which could not be removed as the nature of their work required its use. Secondly, street level bureaucrats experienced *dissonance* as they struggled with vague or ambiguous policy goals and developed *cognitive shields* to manage the tension that arose from high public expectations, and inadequate resources to meet these. Thirdly, Lipsky pointed to the significance of *workplace culture* in maintaining morale and, fourthly, to the paradox of *conflict* co-existing with *reciprocity* in relationships between street level bureaucrats and managers. Each of these is discussed now in turn to locate what, if any, conceptual traction they continue to have in light of this research.

## Discretion

In this study, the factors influencing street level implementation of adult protection policy by social workers cross-cut with Lipsky: there were both echoes of Lipsky, as well as points where the 'time and place' of his thesis (1970s urban America) resonated less with social work in this Authority, in this country, forty years later.

For Lipsky, the work structure of the street level bureaucrat (whatever their role or profession) made the elimination of discretion impossible. A starting point for this research had been speculation about why, apparently, social workers did not implement adult protection procedures when an alert was raised about an older person. I had mused over this when consulting to some other authorities that used the same procedures. In fact, as we have seen in *this* Authority, on the relatively infrequent occasions when alerts were raised about older people, social workers and their team managers did implement procedures, that is, they collected information to reach a view, with other agencies, about whether to continue work within the procedures, or reach an explicit decision not to proceed further within that framework. To that extent at least, Authority social workers and team managers used the procedures when alerts were raised[44]. *Contra* Lipsky, street level bureaucrats and

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[44] Had a larger resource been available for this project, and a second (or third) authority using the same procedures been included as embedded units within this single case, it would have been possible

managers in the Authority liked the procedures — *I'm very fond of them ... I find the procedures great*[45] — and viewed them neither as fettering professional discretion, nor as ambiguous or illegitimate. They exercised discretion in their 'coming in and coming out of POVA', that is, case managing within or outside the adult protection framework. The formalised process of the framework, with its explicit entry and exit points, provided professional 'cover' and a 'certainty of structure' to frame decision-making in highly uncertain situations. 'Cover', for managers and street level bureaucrats, derived from the multi-agency nature of the procedures (even if the co-equal participation of NHS partners was lacking, and police priorities privileged other police work over adult protection investigations); and this provided the protection of multi-agency (not just social services) decision-making[46].

To borrow a Lipskian term, this cover seemed to be a policy *shield*, that is, protection from single agency responsibility for action or inaction. Despite his intention to "identify which features of people-processing are common, and which are unique, to the different occupational milieux in which they arise" (Lipsky 1980:xv), Lipsky did not greatly differentiate social workers from other street level bureaucrats in developing his thesis. In this research, the structure of work — its multi-agency nature — influenced *who* exercised *what* discretion, *where*, *when* and *how*. The exercise of professional discretion was not an 'either/or' process —a crude binarism — but was diffused and nuanced[47]. Using the image we encountered in chapter 2, discretion was exercised within Dworkin's 'doughnut', that is, within the procedural framework that represented, again in Dworkin's terms, the "belt of restriction" that bounded the exercise of discretionary judgement (Dworkin 1978:31).

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to explore differences and similarities across authorities of factors bearing on procedural 'non-implementation' (Yin 2003).

[45] Authority manager.

[46] McCreadie *et al* (2008) also found this in their review of the implementation of *No Secrets* in England.

[47] In this, these findings concur with those of Evans and Harris (2004).

The question, though, was *who* exercised discretion? Implementing, or not implementing procedures, was not a single agency/single professional decision. Social workers, the police, healthcare professionals, regulators, providers, commissioners *et al*, inter-meshed professional assessment and judgement within a procedural framework that, by its very nature, structured decision-making (and hence the use of discretion) — it did not replace it. The text of the procedures repeatedly told its users '*you must consider*', *'you should consult' 'you must reach a decision and record it'*. These mantras — the 'musts', the 'shoulds' — were directions to consider, consult, reach a decision. None removed professional discretion; rather *they directed that professional discretion was exercised*, within the procedural framework (Dworkin's doughnut). The difference between this and Lipsky's analysis forty years before, was the *number* of agencies exercising discretion. Rather than one street level bureaucrat making a decision in a uni-agency bureaucratic hierarchy, decisions were reached by a number of street level bureaucrats in a network of organisations, with distinct yet overlapping remits, roles and responsibilities. In this way, the exercise of discretion was diffused, but it was not removed.

In addition, there were many points at which the identification — the 'seeing' — of elder abuse, and implementation of policy to protect the older person were discretionary, that is not rule-bound but judgement-based. In chapter 3, for example, we noted that a death certificate might state septicaemia as a cause of death, without reference (or investigation) into the neglect that led to the condition underlying cause of death developing in the first place (AEA 2007a). In this way, what was written on the death certificate is an exercise of discretion as well as a record of medical 'fact'. The 'naming' of 'septicaemia', and not neglect, as cause of death forecloses further probing into reasons behind the death.

In this research there were many other points at which discretion, and its conjoined twin 'power', were exercised by social workers and by other agencies. Whether elder abuse was 'named' as such and action taken under adult protection procedures was, in a stark sense, discretionary. In this study, there seemed to be points where tacit tolerance of a situation without assertive professional intervention, demonstrated an exercise of power and discretion by *inaction*. For example, the poor quality of one particular care home, as well as others, was known about by social workers. They talked about it, they were concerned about it, but the whistle was eventually blown

by the regulator. Social workers did not use their professional power to name, challenge or confront the abuse, in this case at least.

Lukes (2005) reminded us that power exists whether or not used: power is a dispositional concept, a *capacity*, not the actual exercise or vehicle of manifestation. Lukes' reworking of his original ideas on power led to revision of his earlier view that power was a binary concept — power over; but rather was better conceptualised as 'power amongst'. In this research, the service and regulatory system that framed and bounded professional decision-making, assessment, placement and review of older people; how care home places were commissioned and paid for, regulated and inspected, were all parts of the fragmented context within which professional knowledge and action (or inaction) were transacted. This fragmentation appeared to *disempower* social workers. In a meeting observed as part of this research, a respondent had commented that "social workers are trained to assess, not to investigate"[48]. This curious comment may have been a reference to the police leading criminal investigations under the procedures, but it said rather more than that. Core social work skills (stripped of the scaffolding of eligibility criteria and associated databases to categorise, cost and contain needs) include, in essence, the ability to: ask good questions, gather relevant information, consider the person in their individual and social context, work with uncertainty, complexity and conflict, to reason, challenge and, ultimately to reach a professional judgment. They are, in fact, *investigation* skills.

The comment quoted here seemed to diminish the contribution social work skills could bring to adult protection investigations, most of which in any case would not involve a criminal investigation. In understanding this, Lukes again is helpful. He suggested power was the imposition of internal constraints that those subject to it come to see as natural (Lukes 1974; 2005). In this Authority, the apparent disempowerment illustrated above, manifested itself in other ways; for example in a certain hopelessness or sense of 'oh well, that's how it is'. There appeared to be a reluctant acceptance that, for example, police investigations take a long time because they have other priorities (and there's not much social services can do about that);

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[48] This had been minuted in the record of the meeting, hence its inclusion here in quotation marks.

some care homes aren't very good (but they're a last resort anyway and we want to keep older people at home); vulnerable older people have the right to make bad choices (and if they've got mental capacity there's not a lot that can be done, if they want to stay in an abusive environment). Here, Lukes' third dimension of power seemed to play out:

> (t)he power to prevent people ... from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things.
>
> *(Lukes 2005:11).*

The acceptance by Authority managers and street level bureaucrats of their 'role in the existing order of things' had been shaken by the large-scale abuse investigation, but the pieces that made up the jigsaw seemed unchallenged before it came to light. As Bauman observed, "power is measured by the speed with which responsibilities can be escaped" (Fearn 2006). Professional power to name and advocate and speak out seemed, on one hand, diluted by the complexity and fragmentation of accountability systems. On the other though, the dominant ideologies of managerialism, partnership, marketisation and the like, had secured compliance — in the *not*-questioning — by persuading street level bureaucrats that the constraints and realities were inevitable, that their power to effect change was limited. How the dissonance implicit in this was manifest is considered next.

## Dissonance

For Lipsky, dissonance was the result of street level bureaucrats struggling with dilemmas inherent in "a corrupted world of service" (Lipsky 1980:xiii), where large caseloads and inadequate resources defeated any idealistic aspirations they may have brought into the work originally. Lipsky (1980:27) located street level bureaucrats' dissonance in the structure of their work, which he summarised thus: resources are chronically inadequate; demand for service exceeds supply; agency goal expectations are conflicting, vague or ambiguous; street level bureaucrat performance is hard to measure; and clients are usually involuntary.

Lipsky suggested street level bureaucrats developed 'cognitive shields' to manage this dissonance and survive in the workplace. Cognitive shields might include blaming clients for their predicament, thus reducing the responsibility of the street

level bureaucrat to achieve anything with or for them. In this study, dilemmas of care (quality and resilience) and dilemmas of resources (quantity and type) were the warp and weft of work with older people, threads that were interwoven into their stories and accounts. Rather than a crude 'client blaming' cognitive shield (denial in other words), small, micro actions or inactions accreted not into a shield (with its imagery of solidity and impermeability), but *masks* that occluded clear vision. As a fencing mask both protects and partially obscures, cognitive masks closed down taking a sharp, clear, wide-angle view to ask *why* those dilemmas existed. They masked the existence of domestic violence in older age and so ruled out, for example, exploring what support, sanctions and structure the older person might want to stay in or leave that situation[49]. The masks foreclosed assertive, persistent questioning of *why* there is an absence of services and support to older people who are abused by partners or other close family members. The masks rendered commissioners, professionals and regulators limited in their capacity to see through, and beyond, the outputs of contracting and regulatory systems that *ipso facto* would not prevent abusive, institutionalised cultures and practices taking root in some care homes. In other words, the masks narrowed the vision of what was seen, excluding the wider social, political and cultural context that framed that view.

The texture of these masks derived both from structural features of social care (fragmentation of service commissioning, provision, care management, regulation and so on), and behaviours of actors working in these structures at this social and historical junction. Layder's realist approach to bridging theory building and theory testing offers us a helpful signpost here. As he noted, people create the world they

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[49] At the time this research was being written up, the charity Action on Elder Abuse was piloting ways of working with survivors of elder abuse that opened up more sophisticated understandings of how the state might therapeutically engage in the private domain of the family. Some abused elders said they did not want to leave or break up the family; rather they wanted support to stop domestic abuse happening. Therapeutic work (backed by criminal justice intervention if necessary) with the elder and family system was being piloted, for example family conferencing, family therapy and systems work. This type of approach takes understanding and intervention beyond simplistic 'either/or' thinking: either we 'turn a blind eye because that's how it's always been', or we 'remove the elder (and if they won't go, there's nothing we can do)'. (*The Elder Abuse Survivors Network*, a presentation by Daniel Blake to AEA's conference *Choosing Protection*, Llandrindod Wells, 6 November 2008).

see (Layder 1993). This 'seeing' is shaped by levels of understanding of the links between three levels: a macro context (in this research, this would include ageism, and ideologies *de nos jours* of choice, independence, personalisation); a meso context (organisations, professional cultures and practices in services), and a micro context (for example, the subjective meanings and values the individual brings to bear on their work with older people).

Cognitive masks do not fall fully formed straight out of 'managerialism', 'care management' or any other supposed enemy of contemporary social work (see, for example, Dustin 2007). Rather they derive from the interplay of macro, meso and micro levels, within a context of time, place and history: specifically in this study, that of social work with older people in general, and elder abuse in particular, in early 21st century UK. They masked a dissonance where knowing some care homes and healthcare services were poor, and knowing the cash put into services and support to older people was lower per head (WAG 2006) than any other user group social services support, resulted in tacit acceptance by default — by not questioning *why* this is. *Why* are resources so limited, and services frequently poor quality for older people? *Why* are some care homes still like the back wards of post-Poor Law geriatric hospitals?

A fragmented service structure with its disparate parts, pots of cash, rules and systems for joining the parts up, distances professionals from abusive situations and circumstances — from vulnerable people in other words. The infrastructure of multi-agency adult protection illustrates the paradox of unintended consequences: in coordinating activity and intervention, the system distances professionals from the elder and instead focuses their gaze on the coordinating system and on the pressures their inter-agency colleagues are under operating the system. Challenge to other agencies – asking *why?*, *why not?*, is mitigated because each agency knows the other is under pressure, they too have little time, little cash. Partnership work that is not mandated has to rely on cutting partners a bit of slack. As Payne (2009: xiii) observed however, organisations do not partner people, people do, and "good social work practice is not just about fitting in with everyone else". Social workers, as regulated, registered professionals, have a duty of care to service users. They are also employees of state agencies, and gatekeepers (*de facto* rationers) of scarce resources (CSCI 2008a). In this tension, Lipsky's observations about resource inadequacy and

the impossibility of maintaining professional ideals, remain as relevant in the early 21st century as they were forty years before. What is different now though is the complexity of the service system within which street level bureaucrats work. This is discussed next.

## Workplace culture

The foregoing examination of dissonance necessarily contains much of our discussion in relation to the importance of workplace culture. Lipsky (1980) contended that workplace culture was critical in maintaining street level morale in the face of the dilemmas, ambiguities and pressures street level bureaucrats face. Forty years on, the workplace culture in this Authority was differently constructed from that which Lipsky depicted, and in two particular ways.

Firstly as we have seen, the 'workplace' was not one place, team or profession, but many. The multi-agency thrust of policy and the 'partnership' *zeitgeist*, the fragmented nature of a marketised service system, have shifted the 'place' of workplace to inter-agency discussions, and inter-agency decision-making[50]. The time and place of 'workplace' in street level elder abuse policy implementation is not one part of one bureaucracy, but is spread across more levels of more agencies.

Secondly and relatedly, the 'culture' of this multi-agency workplace is made up both of *instrumental* duties and responsibilities, as well as *expressive* working relationships, shared histories and experiences of working together (Dalley 1991). The 'understanding' of mutual pressures and difficulties, the tacit tolerance of delays as other agencies are under pressure, are part of this culture. In this, professionals from different agencies have to work together, they are used to working together, and they appreciate and accept the operational and resource pressures faced by others as well as themselves. Conflict, expressed as holding other agencies to account, challenging the actions or inactions of partners, seemed rare. Health Trust and LHB partners were unlikely to wear out their welcome at multi-agency meetings as they rarely attended them, and could not be required to show up. Without the leverage of

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[50] 'Multi-agency' is used here to describe the roll call, or the line-up, of agencies referred to in this policy. 'Inter-agency' is used to describe the decision-making processes and outcomes, of discussions *between* agencies.

mandate (a statutory requirement on named agencies to cooperate), the workplace culture of the wider adult protection system was one that accommodated the contradictions inherent within those arrangements (under-resourcing, the differential engagement of partners, a fragmented service and regulatory system, and so on). This cultural accommodation —'we're all in the same boat'— seemed, as Lipsky had suggested, to be important in keeping the system going. How far it served the needs or interests of abused elders has to be less certain. For those elders destined to die in a care home where institutionalised abusive practices were embedded, the professional accommodations of a multi-agency workplace culture would hold little interest.

### Conflict between Authority managers and street level bureaucrats

Finally, we return to Lipsky's proposition that the relationship between managers and street level bureaucrats was both inherently conflictual and reciprocal. Lipsky held that conflict arose because street level bureaucrats may not accept rules or may have different priorities from managers; whereas managers want consistency, regularity and compliance. Reciprocity resulted from managers accepting informal work processing to protect the organisation, and the difficulties of disciplining street level bureaucrats; whereas street level bureaucrats needed to keep their jobs.

The findings of this research did not support Lipsky's assertions about conflict in three particular ways. Firstly, at the interpersonal or presentational level, street level bureaucrats and Authority managers spoke of their subordinates and superiors as professional colleagues they consulted, and the organisational culture as supportive. The exercise of discretion and judgement was said to be encouraged. The 'us and them' conflicted relationships Satyamurti (1981) had described between social workers and their managers were not in evidence: the culture appeared unified and mutually supportive. Authority managers had not come into their posts through general management or a career in another sector; they were social work-trained and had come up through the operational ranks (senior practitioner, team manager, operational and strategic management in social services) to hold the post they had when this research was done.

Secondly, cost control, awareness of scarce resources, the need to manage limited cash to best effect — the managerialist creed in other words — were raised more

directly by street level bureaucrats than by their managers. Street level bureaucrats spoke, for example, of the costs to a service when a carer was suspended during an investigation. One team manager in particular was concerned to establish facts by interviewing an alert-raiser (more than once if necessary) before calling a strategy meeting, so as to avoid unnecessary costs of bringing professionals together without justifiable reason. Managers spoke of making small bits of cash go further by finding creative ways to deliver services, although as noted, few examples were given of this in relation to abused elders. Managerialism seemed to have been absorbed by street level bureaucrats. They did not subvert the system, they operated it. They were incorporated into it[51].

Thirdly, the rules the adult protection procedures laid down were not resented by street level bureaucrats. Like managerialism, they had absorbed these— *I like a process to follow, I like 'stages 1, 2, 3, 4*[52]. In any case, and as others have found, social workers ask for more structured guidance on their work, not less (see Evans and Harris 2004; Preston-Shoot and Wigley 2002). Street level bureaucrats in the Authority may not have used the procedures a great deal to protect vulnerable elders, but they were glad they had them. The issue beyond this was how far affection for adult protection procedures helped social workers 'see' potential abuse. Findings suggest fondness for the adult protection procedures did not lead to their 'seeing' abuse and taking action, challenging poor practice, or asking searching questions of themselves, and the structures and systems within which they worked.

Reciprocity between managers and street level bureaucrats was a feature of the unified *esprit de corps* presented by the Authority. The question though, was how far this homogeneous culture derived from solidarity in the face of external scrutiny, for example the apparatus of an audit culture, with its performance indicators, intensive data collection, audit and inspection. As the researcher, I could have represented part of this paraphernalia. The performance of this Authority, like all local authorities, is open to public gaze, at least in those areas that fall under an auditing spotlight. As a

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[51] As we have noted, CSCI (2008a) reported similarly in its annual review of the state of social care in England. The Commission found social workers did not always use cash resources available to them, or exercise discretion where they had it, in decision-making and care planning.

[52] Social worker

consultant whose day job involved, *inter alia*, reviewing, inspecting and investigating aspects of performance of public agencies (and often those that had failed in some way), I would certainly fall into the 'external gaze' category, despite this being personal, unfunded, unsponsored research. A heart-sinking 'an inspector calls' moment for me, (and possibly for them) was the first interview with a social worker. Before starting, the respondent asked reasonable questions (why are you doing this? who's paying you?) before declining permission to record the interview, apologising for not knowing what forms were used in the adult protection process, and for having used the procedures just once.

The interview did not last long. It was telling in what it revealed of how research can be viewed, as well as researchers. The 'audit society' and its 'rituals of verification' (Power 1997) have extended far into organisational life and behaviour. Academic research, inspections, reviews, evaluations all begin to morph into one overarching demand on local authorities that they account for (that is, give an account of) their performance. If this is the case, Authority managers and street level bureaucrats might feel they have to present a more unified culture than is their day-to-day reality. However, having interviewed hundreds of staff across many professions, pay grades and sectors, in numerous research projects, reviews and inspections, I doubted this was the whole story. Dysfunctional organisations are quick to manifest in everyday conversation with people who work in them (thus giving the lie to official data-driven accounts). In this Authority, it seemed that learned 'being inspected' behaviour meant some interviewees felt called upon to demonstrate what they knew (as the experience with this interviewee and the vignettes illustrated), as they believed they were being held to account[53].

Where there was a subtle point of divergence between managers and street level bureaucrats was the self-questioning managers engaged in, in the midst of the large-scale abuse investigation. Three managers in particular (the most senior) were openly searching in their reflection about why what was happening in that care home could

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[53] This response had shades of Goffman's (1959) 'front stage' behaviour, the process and meaning of which he likened to a 'dramaturgical' performance. In this research the setting for the front stage behaviour would be the interview with the researcher, and the respondents' 'personal front', or manner of presentation, that of demonstrating they know what is expected of them.

happen amidst all the regulatory apparatus that surrounded it. Their concern seemed to be that of asking questions of themselves, and less so the need at that time to come up with 'answers'. To this extent, the research process seemed to provide a reflective space for senior managers amidst the operational pressures involved in managing the abuse investigation.

Street level bureaucrats, with some exceptions, engaged in this reflective process less. In this, Lipsky's observation that street level bureaucrats perceive their interests differently from managers may be accurate. In this Authority, street level bureaucrats with decades of experience in frontline social work (few in number), were openly discursive in their accounts of practice and processes that permeated their work. As we noted in the previous chapter, some spoke confidently about working with situations of uncertainty and where risks were present (although, as also noted, this did not result in their taking action to challenge poor practice any more than others). These workers had, experience of social work in, variously, child protection, mental health, learning disabilities, and in London Boroughs, English metropolitan or county authorities. In other words, their careers had spanned time and place, and *had been outside social work with older people*. Less experienced social workers, who had specialised during training and worked mainly in older people services since qualification, talked more about (and were less likely to question) the 'people-processing' nature of street level bureaucracy. They were less likely to say they used social work skills embodying support, care and protection in work with an elder in a situation of risk[54]. Wales may well have the UK's first strategy for older people, and the world's first older people's commissioner — laudable policy creations — but their fine intentions to secure a better deal for elders in Wales were unmentioned by street level bureaucrats whose day-to-day reality was people-processing.

Rather than a crude 'care management killed real social work' polemic, these findings present a far more nuanced picture of how professional values and practice are shaped by the social, political and cultural norms. Social work with older people has never really cut the mustard with an ambitious careerist or, more to the point of our discussion, a skilled practitioner aiming to achieve rather more than people-

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[54] CSCI (2008a) also reported assessors who were not social work trained were more likely to assess for services — people-process — than social workers.

processing. As Hugman (1994) reported fifteen years before this research, and when care management had barely been lifted from the policy page, work with older people has always been seen as low status, requiring lower skills levels; work where people-processing, routinisation and routinised responses are the order of the day.

This section has discussed four aspects of Lipsky's analysis of street level bureaucracy. In reviewing these alongside the findings of this research, the tension — contradictory pressures — between inadequate resources and high public expectations, foregrounds both 'then' (1970s urban America) and 'now'. There are a number of differences 'now' however, which we consider in concluding this section.

## Lipsky 'then' and 'now'

There are three particular differences this research highlights in the context street level bureaucrats work in compared to that Lipsky described forty years previously. Firstly, social workers implement procedures to protect a vulnerable elder with inadequate resources *and* within the considerably intensified inspectorial and audit regime that regulates the highly fragmented service and commissioning system. The place at which these 'regime requirements' meet pressure on resources is a pinch point where dissonance sets in, cognitive masks are forged and expectations are lowered — *I suspect what happens really ... is that incrementally ... people adjust their standards ... we keep saying, well are we just about on the side of statutory compliance or not.*[55]. The extent, nature and complexity of fragmentation, regulatory policing and proceduralisation generate their own pressures on street level bureaucrats.

Secondly, the fragmented service and regulatory system has diffused power and discretion across agencies involved in adult protection; for Lipsky discretion was exercised by the street level bureaucrat at the point of encounter with the client. Now discretion can be exercised by professionals who may never have seen the vulnerable adult, but are present at an inter-agency discussion, for example commenting on this or that course of action — *from my point of view (other agencies) don't take anything into account other than their procedures*[56]. The vulnerable elder is not

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[55] Authority manager

[56] Social worker

likely to encounter any or many of those exercising discretion about their protection in these forums. These are micro processes that occur outside the gaze of any box-ticking inspection schedule.

Thirdly, Lipsky's 'blaming the client for their predicament' cognitive shield has evolved to something far less tangible or overt. Our metaphorical 'cognitive mask', like a fencing mask, narrows vision and excludes a wide-angle view of social, political and cultural factors bearing on how older people are 'seen', supported and treated. Considered separately, the lack of NHS engagement in adult protection structures, and care homes for older people that are *just about on the side of statutory compliance*[57], have an air of dreary familiarity about them to those working in contemporary social care services. They are, as it were, unremarkable in their pervasiveness. Add however, the unified *esprit de corps* and a distaste for challenge of poor care, of colleagues or of other professionals, then the cognitive mask occludes further. The 'unremarkable' features combined with those generally considered 'a good thing' (supportive colleagues, cooperating with other agencies) result in stasis, the maintenance of which becomes an end in itself. Here, Lipsky's observations resonate:

> (o)rganizational patterns of practice in street level bureaucracies are the policies of the organization. Thus, workers' private redefinition of agency ends result directly in accepting the means as ends ...
>
> Accepting limitations as fixed rather than problematic ... discourages innovation and encourages mediocrity. It is one thing to say that resources are limited, another to say that the practices arising from trying to cope with limited resources are optimal.

*(Lipsky 1980:144)*

A difference now however from Lipsky's twentieth century urban America, is a regulatory framework that sets national minimum standards for care which, inevitably, become the ceiling not the floor of acceptability. An individual practitioner care planning with an older person may face the dilemma of, say, a 'collapsed domestic care situation' versus 'risk of hospital-acquired infection here' or 'poor care home there'. That dilemma is bounded by another *which at that*

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[57] Authority manager

*moment the practitioner can do nothing about* — 'minimum' care standards that in any case may not be met. That macro-micro tension nails day-to-day reality for the street level bureaucrat. Surround this with the miasma of ageism, increasing levels of dependency, lack of challenge to care or colleagues, all within a complex, diffused and fragmented service and regulatory system, and a toxic fog descends on street level implementation of policy to protect elders from abuse. Thresholds for intervention go up *as a matter of organisational survival*; as Russell (2008) commented, if all concerns led to intervention, social services would collapse. Contradictory pressures of high public expectations and resource shortfalls remain as potent as Lipsky depicted. This research has shown, however, that the context within which street level bureaucrats operate has changed significantly from that Lipsky described.

The remainder of this chapter broadens our discussion further in light of, firstly, the social context of ageing and of ageism in 21st century UK and, finally, with consideration of ethical dimensions of the research findings.

### *Ageism masks*

"Reality starts with a sense of history" Titmuss (1976: 93) advised. As we noted in the previous chapter, Means and Smith (1998) also counselled the need to see the present in light of the past, and to avoid basking in some golden past age — 'it was better when' (hardly ever apposite in relation to care for older people) — or dreaming up something 'new' (that merely repackages embedded past thinking). In services to older people there has been (to recap Means and Smith 1998): an historical failure to establish older people as a priority of health and social care; periodic panic about an ageing population; a continuing assumption that unpaid female care is available; and ongoing debate about how to finance health care, which agencies should plan and deliver services, and who should provide them.

We may see now how the past is playing out in the present. Contrary to any rhetoric of "what matters is what works" (DETR 1998:9), patterns of social care provision for older people are shaped by what is sayable (Scourfield 2006) in the political, social and economic context of the times. The ideological imperative of contemporary social care in 2009 (in England at least, less so in Wales) is personalisation (DH 2006; HM Government 2007; Leadbeater, Bartlett and Gallagher 2008). In the 1980s,

the focus was community not residential care, the ideological legacy of which was evident in the Authority ... *residential and nursing care bad, community good*[58]. However policy is badged up for older people requiring care, the outcomes and its ageist underpinnings may not be good news.

Firstly, the primacy of community over residential provision in service planning led in this Authority as elsewhere, to reduction of that part of the care sector used by older people unable to finance their own care. A barely acceptable care home is not generally a destination of choice for older people without means. There is something rather more going on here than simply a dislike of communal living: the luxury end of the care home market suffers no such stigma. Lloyd (2006), for example, has reported waiting lists for top-end care homes. Looking back just half a century, policy aspirations were high for post-Poor Law residential care. The old master and servant relationship of the workhouse was to be replaced "by one more approaching that of a hotel manager and her guests" (Ministry of Health 1950, cited in Means and Smith, 1998:155), as the workhouse was replaced by "attractive hostels or hotels ... (accommodating people) ... who will live there as guests not inmates" (Garland 1945, *ibid*). The level of investment, though, never matched the aspiration. In 2006-07, half the care homes in Wales failed to meet national minimum standards of cleanliness, decoration, building repair and satisfactory maintenance of equipment (CSSIW 2008b). Over one third of homes (37 per cent) failed to have up-to-date care plans of satisfactory standard for people living in them (*ibid*). Whatever the ideological direction of travel, it seems care for older people is unlikely to become a priority for cash; as Phillipson commented "the elderly are an ongoing problem in society where institutions are geared primarily around issues of production and reproduction" (Phillipson 1977, cited in Means and Smith, 1998:8).

Secondly, policy preference reflects the values of the society that produces it. Ageism is subtle; apparently unquestioned ageist assumptions dig deep into policy discourse. For example, the IBSEN report, an evaluation of pilot schemes for individual budgets (a central feature of personalised services), found older people less enthusiastic about individual budgets than younger adults: "many older people

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[58] Authority manager

supported by adult services do not appear to want what many of them described as the 'additional burden' of planning and managing their own support". This was followed by the quite remarkable statement, presumably unintentional in its ageism: "... it may take time for older people to develop the confidence to assume greater control" (Glendinning *et al* 2008:19), as if 'older people' were some undifferentiated mass needing to buck their ideas up if they wanted to make it in a 'personalised' Brave New World.

Thirdly, in a dualistic world of either/or dilemmas ('has mental capacity, can make bad choice'), the valued trinity of 'choice', independence', 'personalisation' have as their obverse the devalued ' high dependency', 'can't make choice', 'needs constant care'. The social stench of dependency repels when contrasted with the 'happy shiny people' good news stories about personalised services for empowered and independent elders. In this aversion of the social gaze, in this failure to 'bear witness' as it were, is where we may understand how "dependence has become a dirty word: it refers to something which decent people should be ashamed of" (Bauman 2000:5).

Just as the status of those dying is liminal (neither in the world nor departed from it), very dependent elders become socially liminal. They don't quite fit the bill in a 'sixty is the new 40' world where energetic, sexually active, physically attractive old age is packaged as the aspirational goal of baby boomers with time and cash on their hands. Very old, frail, highly dependent people are rendered invisible, socially liminal, not quite that which we wish to see. Except these elders (disproportionately women), without wealth, without mental capacity, and possibly without family, are *dependent*. They are at greater risk of abuse, in this Authority as elsewhere in the UK, although that too may not be 'seen'. Their human rights in healthcare may be badly compromised (JCHR 2007a; 2000b). They are unlikely to become priorities for state spend on social care; as Kittay (2001a:546) remarked "the labor of care always seems too expensive". Further, and this leads to the concluding part of this discussion, dependency cannot be wished away. Rather it is "the elephant in the room of discourse around many ethical, social and political issues" (Kittay, Jennings and Wasunna 2005: 445). It is to some ethical issues raised by this research that I now turn to conclude this discussion.

## *A question of ethics*

The words 'ethics' and 'ethical' did not come up very often in interviews or focus groups. Neither did they for the researcher when the first tentative cuts at shaping up the study were at drawing board stage; the renewed interest in the ethics of care[59] made only a passing impression on this study's early literature review. As data analysis got underway, the missing 'ethical voice' in the discourse and narratives of understanding elder abuse and policy implementation was noticed. The fragmented, regulated, marketised world that street level bureaucrats inhabited, substituted needs assessment, arranging, monitoring and regulating *services* — 'transactional' social work to borrow Beresford's (2008) phrase— for humanistic practice based on an ethic of *care*. The final section of this chapter considers this in the context of these research findings and Lipsky's thesis of street level bureaucracy. In this, it trails observations made in the concluding chapter.

How practitioners demarcate 'the ethical' influences their perceptions of their ability to act (Banks 2008). In social work, 'ethical issues' are usually raised in relation to difficult cases or decisions, or found in the profession's code of practice. The context framing ethics is often viewed as 'policy' or 'politics' (the world of hard choices, tough decisions and the like) happening 'out there', rather than here and now (Lloyd 2004; Sevenhuijsen 1998). Banks (2008) noted that individual decision-making cannot be abstracted from its political and policy context. She may also have added its *social* context; as we noted, that of ageing, ageism and an abhorrence of dependency, as Lloyd (2006) described it.

Ethics cannot be demarcated out of micro, meso, or macro decision-making around elder care, and justice and rights of the older person. Gilligan (1982) first linked care with justice, identifying differences in conceptualising the two. Conceptualisation was typically dualistic: justice was abstract, universalist, masculinist, impersonal and in the public domain; care was individualised, within the home and family, feminised and private (Fine 2007). This dualism came under challenge from feminist ethicists. Crittenden for example, asserted principles of care can provide universal moral principles, if they both supply moral guidance in the public as well as private

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[59] In social work, see for example, Banks (2008), Lloyd (2006), McBeath and Webb (2002).

spheres, and can be developed as a set of abstract principles to regulate public life (Crittenden 2001, cited in Fine, 2007). An ethic of care meets both of these conditions she suggested. In her work on moral boundaries, Tronto (1993) differentiated care and protection and, as our concern here relates to both, Tronto's work may offer ethical insight to our research findings.

Care, Tronto suggested, involved taking the needs of the other as a basis for action; protection presumed bad intentions from another and so required a response to potential harm. Tronto (1993:103) defined care very widely as a "species activity that includes everything that we do to maintain, continue and repair our 'world' so we can live in it as well as possible". That 'everything that we do' involved four phases: caring about, taking care of, care giving, and care receiving.

Tronto delineated four elements of an ethic of care, which capture many of the themes of this research. Firstly, *attentiveness* — noticing needs is a primary human task. *Not* seeing, *not* attending, *not* noticing are, within an ethical framework, moral failings. Secondly, the element of *responsibility* is central to a care ethic. A tricky concept, responsibility is often perceived only as duty and obligations. Instead, Tronto suggests that responsibility is embedded in cultural practices, not in rules. We might say the *ability* to *respond* to the other — to act in other words — is a measure of social or professional morality.

The third element — *competence* — is necessary to counterbalance 'taking care of' with 'care-giving', as "intending to provide care ... but then failing to provide good care, means that in the end the need for care is not met" (Tronto 1993:133). Setting aside resource shortfalls (although she contended competence was compromised without adequate resourcing), Tronto asked "how could it not be necessary that the caring work be competently performed in order to demonstrate one cares?" (*ibid*). Here we may understand why, simply (as it were) placing an elder in a care home — taking care of — is morally vacuous, without also ensuring that the end result — the quality of care — is competent[60].

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[60] Kittay (2001b:560) included 'attitude' within the ambit of competence: care work "unaccompanied by the attitude of care cannot be good care".

Tronto's fourth moral element was *responsiveness*, of the care giver to the care receiver. Needing care places the person in some vulnerability: the response made to that vulnerability has moral consequences. The myth of the autonomous and independent individual is again laid bare; as Bauman (2008) observed, everyone is fragile as some point in time. Political (or care) systems that elevate autonomy and independence above all other, pathologise, make less than fully human, render as 'other' those who are vulnerable. The moral element of responsiveness requires we stay alert to "the possibilities for abuse that arise with vulnerability" (Tronto 1993:133).

Finally, for Tronto, good care requires that the four phases of care (caring about, taking care of, care giving, and care receiving), and the four elements of an ethic of care (attentiveness, responsibility, competence and responsiveness) form a whole: that is, they *have integrity*. The means by which this happens must be more than beseeching others to do this or that, or codifying rules into policies, procedures and professional codes. This is where an ethic of care gets *personal*. 'Personal' in that caring practice requires, in Tronto's words "a deep and thoughtful knowledge of the situation, of all the actors' situations, needs and competencies" (Tronto 1993:136). 'Personal' caring practice derives from social, cultural and political contexts that bear on the care giver, the care receiver, and the exchange of care. Those caring must make complex judgements about needs and how to meet them; such judgements derive from personal awareness of the construction and manifestation of needs within a wider social, cultural and political context.

Whilst open to reasonable criticism for defining care very broadly (Sybylla 2001) or for locating too closely in the perspective of the carer, not cared-for (Lloyd 2006), Tronto's four elements of care illuminate some of the findings of this research.

Tronto opened up some ethical space to see the social and political context of care and justice as matters of morality. Street level implementation of policy to protect vulnerable elders takes place within this context: the act or acts of implementation have a moral dimension.

Firstly, this was an Authority where street level bureaucrats and managers were open to this research exercise; its organisational culture was supportive and collaborative. These are both positive levers to press in developing constructive critique. However, the social and political context of their work mitigated alertness — their *attentiveness*

— to this. Barely acceptable situations for older people ... *you calibrate what's acceptable to what you know ... you operate in that real world ...*[61] became, if not unremarkable, the operant conditions of that 'real world'. Constructive critical challenge was not embedded into discussion at all levels (service planning, management and delivery) and with all partners although, as we saw, the large-scale abuse investigation had opened up some questioning by managers ... *all this activity that goes on often doesn't seem to get to the heart of how people are living and being cared for ...*[62]

Secondly, professional ways of 'seeing' and 'not seeing' cognitively masked what we might call the 'real world' of elders, framed as that is by the same social and political context. An 85 year-old woman with severe rheumatoid arthritis, cared for by her 93 year old husband, has unexplained bruising ... *you go from 'this is abuse and is being done deliberately' to hang on a moment, to care for someone who's elderly is quite hard work ...* [63] Here, the either/or of abuse (and no doubt the scores of similar situations that street level bureaucrats had across their computer screen that day) masked the 'real world' within which two very old people were living. Attentiveness and responsiveness to the lived reality of these two older people (and care of another dependent being *is* 'hard work') was constructed in the policy paradigm street level bureaucrats operated, and the rules — the procedural processes they followed.

Thirdly, documents supplied to this research were, as we saw, often incomplete or unfinished. Data were not reliable; analysis was rudimentary. The adult protection coordinator post was part-time. Three incumbents had held this post in three years; two were temporary appointments; the post had been empty for some months. These are familiar patterns for people working in human services, where delays in making appointments and bits of money pushed around here and there, are everyday reality. They also say something more though, about the attentiveness to elder care and elder abuse, as some in the Authority recognised ... *you can add all the usual money and*

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[61] Authority manager

[62] Authority manager

[63] Team manager

*things like that but I think… strategically it's about giving it attention*[64]. 'Facts' such as Wales having the highest rate of elder abuse in the UK, as well as high rates of domestic abuse in old age relative to other UK countries[65], had not focused Authority attention on *why* its own elder abuse referral rate seemed low, or on *whether* its social workers were 'seeing' abuse. Further, the moral *responsibility* of challenge to poor practice, delays, the 'barely acceptable', fell through the cracks of a complex system that fractured responsibilities into discrete parts that may not join up to deliver the goods. This was not a badly run authority; it was open, supportive and welcoming of this research attention as an opportunity to learn, yet the constraints and realities it operated in *masked* seeing how these micro-accommodations both influenced, and were influenced by, macro contextual factors.

Tronto's four elements of an ethic of care provide some ethical purchase to grasp how constraints and realities experienced by street level bureaucrats and their managers —Lipsky's 'dilemmas' —inform, and are informed, by macro, meso and micro level decisions, commitments and values. At each level, ethical and moral decisions are made, whether by omission or commission. Cognitive masks occlude vision of the context within which street level bureaucrats work, and of ethical dimensions of the small, the everyday, and the 'real world' they inhabit. In this, an ethic of care, and Tronto's four elements of care, add a further dimension to these research findings, and to Lipsky's concept of street level bureaucracy. The dilemmas of the individual in public services are also dilemmas of ethics, although as this research has shown, are rarely construed as such.

In locating these masks this discussion has journeyed widely. In this chapter, I have reviewed research findings in relation to Lipsky's four propositional concepts of discretion, dissonance, workplace culture and conflict. Developing Lipsky's analysis of dissonance, and taking his metaphor of 'cognitive shields', this research has identified the cognitive masks that constrain, occlude and frame how street level bureaucrats and their managers implement policy to protect vulnerable elders. I have considered the wider social and cultural context that delivers up ageism and aversion

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[64] Authority manager

[65] As reported in the UK prevalence survey (O'Keefe *et al* 2007).

of dependency, and its bearing on local policy implementation. Finally, I have discussed Tronto's four elements of the ethics and morality of care, and the additional dimension these offer to understanding the research findings, and street level implementation of policy to protect elders from abuse.

In the concluding chapter, I review Lipsky's concept of street level bureaucracy, and the contribution this research makes to evaluating, developing and updating his thesis, and to understanding street level implementation of policy to protect elders from abuse in 21st century UK.

# Chapter 7 Conclusion

This was a small-scale, tightly-bounded research project whose findings have extended somewhat further than anticipated when the simple 'I wonder why? ...' question was posed in the draft research proposal. The final chapter concludes by identifying the contribution this research makes to understanding street level policy implementation to protect vulnerable elders from abuse, and to validating and developing Lipsky's thesis of street level bureaucracy. The chapter identifies areas where further research is needed. It highlights some implications for policy and practice. Finally, concluding comment is made about the need to link, conceptually, Lipsky's contribution to understanding street level bureaucracies with enhanced understanding of the ethics and morality of policy implementation to protect elders in street level bureaucracies.

## *The research contributions*

This study makes two particular contributions to understanding of street level policy implementation. First, the research has critiqued and developed Lipsky's insights on street level bureaucracy for 21st century UK social work. Second, it has identified how macro, meso and micro factors interweave to create 'cognitive masks' that occlude understanding and 'seeing' elder abuse. I discuss each contribution in turn.

### Updating Lipsky

This research was written up in late 2008. At that time the circumstances surrounding the death of 17 month-old Baby P, subject to a child protection plan of Haringey Council, had been made public. At its previous inspection, Haringey had a three-star rating from Ofsted, the English children's services regulator, whose mission statement is 'Raising Standards, Improving Lives'. The data on which Ofsted's judgement was based had been generated by a bureaucratically perfect system: "Haringey had a beautiful paper trail of how they failed to protect this baby", Eileen Munro, a social work academic, observed[66]. A few weeks before this, several large global banks and finance houses collapsed. These, too, had been highly regulated and deemed fit to practice under those auditing regimes.

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[66] Eileen Munro quoted in Caulkin (2008).

The regulatory regimes of marketised, privatised welfare bureaucracies (or globalised banking systems for that matter) were not part of the landscape inhabited by Lipsky's street level bureaucracies. This research has identified the subtly powerful impact they have on factors influencing policy implementation, and have added something to Lipsky's 'story' of street level policy implementation. In addition, I have highlighted how social and cultural factors, like ageism and a cultural disgust of dependency, permeate decision-making (at the micro level), service planning (meso level) and policy making (the macro level). While Lipsky's fundamental narrative remains valid — that the problems of street level bureaucrats lie in the structure, system or organisation of their work — this research has enlarged our understanding of that structure, and the impacts it has on street level implementation of policy to protect vulnerable elders.

I have identified where core elements of Lipsky's thesis remain valid. Firstly, this research has confirmed discretion cannot be removed from street level decision-making: it has, however, significantly developed our understanding of this. It has illustrated how the exercise of discretion and power is diffused and spread across a complex network of agencies expected, but not mandated, to work together to protect vulnerable elders. Secondly, it has confirmed that workplace culture continues to be a powerful shaper of professional behaviour. Now, however, 'workplace' is communication between a plethora of agencies expected to coordinate their efforts to implement adult protection policy. And in this coordinated-but-not-mandated arrangement, challenge and critique may be sacrificed in the spirit of partnership and getting the job done. Thirdly, this research has pointed up the fragmented, regulated service and care world of the 21st century UK street level bureaucrat. It has exposed some fault-lines in this system. Commissioners contract on quality standards with a home, regulators inspect it, social workers review the care plans of those they place there; and yet low level abusive noise may not be heard or, if it is, may not be silenced.

This starts to become 'the real world' that street level bureaucrats talk about. In this research, as for Lipsky forty years before, adjustments and accommodations are made by the street level bureaucrat to their real world. The dissonance arising where high expectations meet Lipsky's 'corrupted world of service' would be as familiar to one of Lipsky's street level bureaucrats as to a social worker in this Welsh authority.

This research has suggested how this dissonance finds form, in particular in the workings of 'cognitive masks'. It is to this contribution I now turn.

## Unmasking contexts

Drawing on Lipsky's metaphor of 'cognitive shields' (tucked away on page 153 of *Street-level Bureaucracy*), the second significant contribution of this research is the conceptual development of 'cognitive masks' to describe how contextual factors are the threads woven into the stories and accounts of the dilemmas of street level bureaucrats. Just as a fencing mask protects and partially obscures, cognitive masks close down taking a wide-angle view to ask *why* those dilemmas exist.

Understanding how cognitive masks occlude or obscure vision of an elder's situation is an important finding of this research. The research has suggested elder abuse is 'not seen' or acted on— is cognitively masked — by ageism (domestic abuse services that are not age-aware, for example), by low expectations of services for vulnerable, old, frail elders, by people-processing practices of volume delivery. 'Either / or thinking' cognitively masks 'seeing' what may be a painfully real (but obscured) situation of, say, a severely disabled 80 year-old woman, intentionally, coldly and violently emotionally abused by her spouse and sole carer, and over protracted periods characterised by an angry, intense, silent, misogynist contempt of dependency. This research has suggested domestic abuse like this may not be noticed or, if it is, be construed as a long-standing relationship feature, or a matter of 'choice'. The multiple oppressions and their consequences for this woman, are likely to be masked by ageism, a lack of age-appropriate services for older abused woman, and the ideological policy preferences of the day.

This research has indicated a number of areas where future attention should be directed, and the next, penultimate, section of this study considers these.

## *The research future*

As difficult as access issues are, finding out about the experience of abused elders is a pressing need, and one raising a number of questions. Did they report their experiences, if so, to whom and with what outcome? For how long were they abused? What help, support or services helped or would have, had they been available? Whilst this research and Lipsky's work focused on the street level

bureaucracy and the street level bureaucrat, as we noted in chapter 6 a further factor bearing on understanding policy implementation must also be the experience, and the voice, of the elder.

Secondly and relatedly, the difficulties of researching abuse in care homes is a hurdle yet to be tackled, still less overcome in the UK[67]. It is urgently needed as elders experiencing poor care and low level abusive 'noise' in a barely regulatory compliant care home, are likely to die in that environment. Without understanding the experience of abused elders, adult protection structures are likely to develop ever more refined bureaucratic systems that may hit various targets but *miss the point*, which is that policy implementation and adult protection structures are a means not an end. This research, in identifying cognitive masks, has illuminated a means to see through the masks and relocate attention to the older person in these environments.

Thirdly, we need to understand better how to elevate ethics and morality to a point beyond mere rhetoric — for like apple pie and motherhood, who could gainsay ethics? Research examining if and how an ethic of care may be secured within the work of street level bureaucracies, and the wider, organisational policy context within which they operate, would push our understanding beyond its present limits.

Finally, to keep the enterprise manageable, the multi-agency nature of policy implementation was contextual, not central, to this research. Given findings that workplace culture is the 'the many not the one', then research on factors influencing multi-agency implementation of policy to protect vulnerable elders would be fruitful for future work, particularly as England and Wales are, at early 2009, consulting on revision to national adult protection policy guidance (DH 2008).

### *Ethics and street level bureaucracy*

As discussed in the previous chapter, the dilemmas street level bureaucrats and managers described in this research were not generally framed as matters of ethics, rights or justice. In the concluding chapters of *Street-Level Bureaucracy*, Lipsky deliberated about the potential for reform of street level bureaucracies, considering various organisational responses to the dilemmas and ambiguities that permeated the

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[67] See Mowlam *et al* (2007) for some of the difficulties encountered.

work structure, and hence the work of, the street level bureaucrat. In none of this discussion, were the ethical dimensions of human transactions within street level bureaucracies directly mentioned. In other words, Lipsky's powerful and enduring analysis of street level bureaucracies returned, in the end, to considering strategies to make them 'work better'. To be fair, Lipsky was under no illusion that organisational 'solutions' such as more training, opportunities for deliberation in the workplace and so on, would be more than palliative in effect, as street level bureaucracies were part of "organisational relations in the society as a whole" (Lipsky 1980:192). This research however, has added to Lipsky's analysis, by locating an absence of ethical discourse in street level policy implementation and wider service planning, delivery and systems. Further, it has identified, after Lukes, how street level decision-making is imprinted with imposed internalised constraints, such as cost control and a distaste for challenge — illustrative of acceptance by street level bureaucrats of their 'role in the existing order of things' (Lukes 2005).

Without focusing ethics to the centre, not periphery, of policy design and implementation to protect elders, we are likely to witness a search for ever more rules, protocols and procedures, designed to make commodified, fragmented service and regulatory systems function 'better', and for responsibilities to become ever more rule-based, rather than ethically-driven. Tronto (1993) was perceptive in her location of 'responsibility' in cultural practices, not rules. Lipsky, too, concluded that developing more rules was likely to be futile; rather he saw the need to "secure or restore the importance of human interactions in services that require discretionary intervention or involvement" (Lipsky (1980:xv).

Such human interactions take place within the contextual complexity that frames street level bureaucrats' work. The impacts of this complexity are occluded by the cognitive masks this research has identified, which serve to protect street level bureaucrats and managers from the dissonance arising from their work, and the social, political and cultural context that frames it. From an ethical vantage point, cognitive masks occlude seeing moral inadequacy when professional power and discretion are not exercised in favour of an elder. Ethically, masks hinder seeing *competence* in full beam as a matter of morality as well as of standards: for when 'competence' is measured by minimum standards or compliance with rules, *processes* are emphasised, not people. Cognitive masks close down sustained

challenge and critique, on moral grounds, to the moral need for adequate resourcing to provide competent care[68].

Mainstreaming ethics to the heart of policy formation and delivery, at all levels, holds out the possibility that policy making, inadequate resourcing, poor care and people-processing practices of street level bureaucracies can be exposed to ethical, as well as rule-based, scrutiny. Without this critical scrutiny, without removing the cognitive masks — in other words, understanding the consequences of these practices — learning is too often outsourced *post hoc* to large investigations, inspections, serious case reviews and the like *when things have gone badly wrong*. This results, often, in the narrative (usually of failure) being constructed by external 'experts' who will judge failings against standards, not an ethic of care (Butler and Drakeford 2005). More rules and structural reform often result (as was seen following the death of Victoria Climbié[69]), but wider systemic contexts remain unquestioned, and cognitive masks stay firmly in place.

This research has implications for policy-makers and those who manage and directly deliver services to elders. Rational, rule-based policy making, may be necessary but it is not sufficient to safeguard vulnerable elders, if resourcing (cash, people, bricks and mortar) is institutionally ageist, dependency-averse or *zeitgeist*-propelled. Instead, ethically-driven policy making should favour, and resource, structures and systems that emanate, as it were, a 'socially-just duty of care' to the vulnerable elder at risk of abuse. If, as this research has shown, the problems of the street level bureaucrat lie in the systems and structure of their work, then those need a clear, unblinking policy gaze at the complex, under-resourced service and regulatory systems that claim the attention of the street level bureaucrat. Street level bureaucrats have a professional duty of care to an abused elder; the social and policy context within which they operate must support their discharging this duty.

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[68] In this, England's (1986) identification of social work as 'art' is apposite. As in art, criticism helps understand social work as subjective and value-laden. This 'critical' approach, in a philosophical sense, opens up space for moral questions to be asked.

[69] The first 17 recommendations of the Laming Report on the inquiry into the death of Victoria Climbié concerned reform to structures and information systems. (Secretary of State 2003).

One implication of this research for managers and street level bureaucrats is simple, yet challenging. Removing the cognitive masks requires the development of organisational cultures that not only encourage challenge to everyday (not just poor) practice, *but expect it*. Such cultures would invite *and require* critical thinking and questioning; managers who model reflexivity and develop it in their staff, and encourage reports of 'near misses' (poor or risky practice) as well as exemplary work. In such cultures managers would ask, routinely, why there are no or few whistle-blowers, and staff would feel professionally confident in challenging each other as well as other professionals. Such cultures would relish self-challenge and encourage professional debate as a matter of course. These implications for policy and practice do not, therefore, fall into a neat tick-off list of linear, discrete recommendations. Rather the research message to policy makers, managers and street level bureaucrats is 'wake up!' — recognise, and remove, the cognitive masks.

Finally, this research odyssey set sail by speculating about factors bearing on implementation by social workers of policy to protect elders from abuse, and whether Lipsky's concept of street level bureaucracy had continuing salience in understanding street level policy implementation. The research identified a range of significant influences on street level decision-making by social workers. It concluded that Lipsky's thesis has enduring validity; it has shown where the concept requires updating to a contemporary social, political and cultural context, and supplementing to embrace morality in its analysis of street level practice and policy implementation to protect elders from abuse. The journey ends in recognising that Lipsky gave us important analytical tools to understand the structure and dynamics of street level bureaucracies, and the dilemmas street level bureaucrats face. This research has, however, sharpened, updated and expanded Lipsky's analytical toolkit to illuminate factors bearing on street level implementation of policy to protect elders in 21st century UK social work.

## Postscript: corrupted worlds, cognitive masks and slippers

As we had agreed, I met the Authority head of adult services to discuss the research findings after data analysis was completed. We talked about 'not seeing', 'not

challenging' poor care, about ageism, ethics and morality — 'big' questions, hard to peg down in the action-planned, task-listed world of a street level bureaucracy.

Then the head of service mentioned the home investigated at the time this research was being done, and the old, caked vomit found on the slippers of a person living there.

We fell silent, considering this. Lipsky's 'corrupted world of service', cognitive masks and morality suddenly collapsed into that one image, of old, caked vomit on an elder's slippers.

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UNIVERSITY of BRISTOL

School for **Policy Studie**

8 Pnory Road, Bnstol, BS8
T . +44 (0)117 954 6
F : +44 (0)117 954 6
W : http.//www bris.ac uk/Depts/S

## Appendix 1 Information sheet

I'm doing some personal research looking at the realities and constraints for social workers and team managers when adult protection concerns are raised about an older person. I'm doing the research for a higher degree at the University of Bristol.

I'd like to meet you as part of the research. Your agency has agreed that I can talk to social workers and team managers of community care teams, as well as other managers involved in the protection of vulnerable adults in your department.

This sheet explains what the research is about. Please read it and decide if you are willing to be involved.

### What's the research about?

In 2000, the Assembly published *In Safe Hands*, national guidance to protect vulnerable adults. Following this, your agency developed and launched multi-agency 'POVA' procedures to protect vulnerable adults.

My research is interested in finding out about the realities and constraints for social workers and team managers when dealing with concerns and alerts about possible abuse of an older person.

The research **isn't** about evaluating the POVA procedures or your practice.

### Why have you been chosen?

You are being invited to take part because of your work with older people, and in the protection of vulnerable elders from abuse. This may be as a practitioner or manager, or someone on your local Area Adult Protection Committee. The research is interested in gathering views and experiences, from practitioners and managers, of dealing with concerns about possible abuse and alerts concerning older people.

**Who's doing the research?**

I work independently, mainly doing health and social care research and consultancy. I'm a Registered Social Worker, and have a strong professional interest in the protection of vulnerable elders.

The research has no external funding or sponsorship, and it hasn't been commissioned by your agency or any other.

**What's involved if you take part?**

I'd like to meet you to talk about your (or your staff's) experiences of dealing with concerns or alerts about possible abuse concerning older people, the things considered in decision-making and actions taken.

I'll also ask teams if they're willing to take part in a focus group to talk about these themes.

I'd like to tape our conversation, with your agreement, so that I can listen to it afterwards. If you didn't want the tape used, I'd write notes while we talked.

**Do you have to take part?**

It's up to you to decide whether or not to be involved. If you meet me, you're free to stop the interview at any time. If you want to stop, you don't have to give a reason.

**What happens to information you provide?**

All information collected during the project will be kept strictly confidential. It will be stored anonymously and will only be identified by a code. Only I will have access to the information collected. Information will be destroyed two years after the project is completed, or in compliance with any timeframe of new EU guidance if such is issued during the time the research is being done.

The final report will be anonymised so that the identity of people won't be disclosed. Findings from the research, including quotes, will appear in the final report. This will be in the public domain if a degree is awarded, and may appear in published articles.

If during the interview I (or you) learn of serious matters that have, may or will put an elder at risk, I would discuss these with (agency manager) or other appropriate person.

**Need more information?**

If you need more information about the research, please contact the researcher **Angie Ash on (landline), at Angie.Ash@bristol.ac.uk, or write to (address).** Alternatively you can contact the research adviser **Dr. Liz Lloyd, Senior Lecturer, School for Policy Studies, University of Bristol on 0117 954 6707** or write to the address at the top of this sheet.

If you have questions about your agency's involvement in the research, please contact **(agency manager).**

UNIVERSITY of BRISTOL

School for **Policy Stu**

8 Priory Road, Bristo
T : +44 (0)117
F : +44 (0)117
W : http://www.bris.ac.uk/

## Appendix 2 Participant consent form

*Please tick the box to indicate 'yes'*

| | |
|---|---|
| Have you read the information sheet? | ☐ |
| Have you had an opportunity to ask questions about the research? | ☐ |
| Have you received enough information about the research? | ☐ |
| Do you understand your participation is voluntary? | ☐ |
| Do you understand that you are free to withdraw from the research at any time, without giving a reason? | ☐ |
| Do you understand that any previously undisclosed serious practice concerns that emerged during the interview would be raised with an appropriate person? | ☐ |
| Do you agree to participate? | ☐ |
| Do you agree to the interview being tape recorded? | ☐ |
| Do you agree to allow anonymised quotes to be used in the reporting of the findings? | ☐ |

| |
|---|
| **Your name** |
| **Date** |
| **Signature** |

## Appendix 3 Topic guide: social worker

- Introduce self.
- This is independent, unfunded, non-commissioned research.
- The dissertation will be in the public domain if a degree is awarded.
- The research is looking at the factors influencing social workers and team managers - constraints and realities – when contemplating use of adult protection policies to protect older people from abuse.
- Explain issues to be covered:
  - Respondent's role, experience, background
  - Topic areas
- Explain use of transcripts (researcher access only, maybe university)
- Anonymity of responses given. Elders' names or identity is neither sought nor required.
- Confirm mutual duty of care to report any serious concerns that may emerge that have, will or may put an elder at risk. (Confidentiality is not therefore absolute).
- Questions? Can stop interview at any point without giving a reason.
- Permission to tape interview?
- Confirm informed consent. Participant sign consent sheet.

---

**1. Your work with older people**

Current/past. Settings, experience.

**2. Tell me about your experience of dealing with alerts or concerns about an older person under the adult protection procedures**

*Describe some cases – where procedures used, not used.*

*What you did. Your manager. The outcome.*

*What sort of things were you factoring into your decision-making? Probe – thresholds for intervention.*

*Why are referral rates lower here for older people than other vulnerable adults?*

*Domestic abuse – examples?*

**3. How much discretion would you say you have when dealing with alerts? And your manager?**

*Examples*

**4. Sometimes the quality of services older people receive is poor, what do you do if you encounter this?**

*Probe – challenge, organisational expectation/permission*

**5. Your view of the adult protection procedures – how far have they helped or hindered you in adult protection of older people?**

End. Thank.

# Appendix 4 Topic guide: team manager

- Introduce self.
- This is independent, unfunded, non-commissioned research.
- The dissertation will be in the public domain if a degree is awarded.
- The research is looking at the factors influencing social workers and team managers - constraints and realities – when contemplating use of adult protection policies to protect older people from abuse.
- Explain issues to be covered:
    - Respondent's role, experience, background
    - Topic areas
- Explain use of transcripts (researcher access only, maybe university)
- Anonymity of responses given. Elders' names or identity is neither sought nor required.
- Confirm mutual duty of care to report any serious concerns that may emerge that have, will or may put an elder at risk. (Confidentiality is not therefore absolute).
- Questions? Can stop interview at any point without giving a reason.
- Permission to tape interview?
- Confirm informed consent. Participant sign consent sheet.

---

**1. Your work with older people**

Current/past. Settings, experience.

**2. Tell me about your experience of dealing with alerts or concerns about an older person under the adult protection procedures**

*Describe some cases – where procedures used, not used.*

*What sort of things were you factoring into your decision-making? Probe – thresholds for intervention.*

*Why are referral rates lower here for older people than other vulnerable adults?*

*Domestic abuse – examples?*

**3. How much discretion would you say you have when dealing with alerts?**

*Examples*

**4. Sometimes the quality of services older people receive is poor, what do you do if you encounter this?**

*Probe – challenge, organisational expectation/permission*

**5. Your view of the adult protection procedures – how far have they helped or hindered you in adult protection of older people?**

End. Thanks.

## Appendix 5 Topic guide: Authority manager/policy maker

- Introduce self.
- This is independent, unfunded, non-commissioned research.
- The dissertation will be in the public domain if a degree is awarded.
- The research is looking at the factors influencing social workers and team managers - constraints and realities – when contemplating use of adult protection policies to protect older people from abuse.
- Explain issues to be covered:
- Respondent's role, experience, background
- Topic areas
- Explain use of transcripts (researcher access only, maybe university)
- Anonymity of responses given. Elders' names or identity is neither sought nor required.
- Confirm mutual duty of care to report any serious concerns that may emerge that have, will or may put an elder at risk. (Confidentiality is not therefore absolute).
- Questions? Can stop interview at any point without giving a reason.
- Permission to tape interview?
- Confirm informed consent. Participant sign consent sheet.

---

1. What is your job and your role in relation to adult protection and older people

- Key areas of responsibility?
- How does this dovetail with (other mgrs), teams, management/policy infrastructure?

2. Policy implementation

- History of implementation. Your involvement.
- What is your implementation plan (then/now)?

3. Procedures and practice

- 'Uncertain' concerns about potential abuse of an older person: can you give a couple of examples of cases where one was managed *outside* the adult protection framework, and one *inside*?
- Information gathering, 'pre-investigations' (*sic*) before a strategy meeting: what would you expect teams to be doing?
- Local custom and practice: do teams work in much the same way in relation to using the procedures to protect older people? *Probe - Local cultures in teams?*
- What discretion would you expect DSOs and social workers to exercise when dealing with alerts about potential abuse? *Probe –is this encouraged, discouraged? Examples*
- To what extent do social workers and team managers challenge poor practice in relation to elder care? As a commissioner, how far does the Authority uphold/ challenge quality *Probe – how much is this encouraged/expected.*
- Why are referral rates lower here for older people than other vulnerable adults?
- The scale of domestic abuse and elder abuse is becoming known, how many referrals are you dealing with of domestic abuse of older people? Are support services interconnected as far as older people are concerned? (domestic violence, MARAC, AAPC etc).
- End. Thank.

## Appendix 6 Topic guide: team focus group

- Introduce self.
- This is independent, unfunded, non-commissioned research.
- The dissertation will be in the public domain if a degree is awarded.
- The research is looking at the factors influencing social workers and team managers - constraints and realities – when contemplating use of adult protection policies to protect older people from abuse.
- Explain issues to be covered:
  - Respondent's role, experience, background
  - Topic areas
- Explain use of transcripts (researcher access only, maybe university)
- Anonymity of responses given. Elders' names or identity is neither sought nor required.
- Confirm mutual duty of care to report any serious concerns that may emerge that have, will or may put an elder at risk. (Confidentiality is not therefore absolute).
- Questions? Can stop interview at any point without giving a reason.
- Permission to tape interview?
- Confirm informed consent. Each participant sign consent sheet.

---

**1. About you...**

Introductions

Have you done adult protection training?

Dealt with adult protection alerts concerning older person?

**2. Do you discuss adult protection concerns about elder as a team?**

Sort of issues you'd talk over in the team? An example?

What sort of things did you consider when deciding what action to take?

Did you use the adult protection procedures in this case?

**3. Sometimes things aren't clear cut** when concerns are raised... sometimes a bad relationship between a couple can be a factor, have you had any concerns like that? *Probe domestic violence*

**4. What if an older person with capacity** says I'm not leaving this situation or I don't want you doing anything? Have you had anything like that happen? What did you do?

**5. What sort of discretion about talking action or not do you have? What sort of alternatives might you weigh up?** How much scope do procedures give you in deciding what action to take if an alert's been raised?

**6. Reasons for lower referral rates here for older people cf other vulnerable adults?**

**7. How far do you feel adult protection procedures help** you in your work to protect elders? **Hinder you?**

## Appendix 7 Topic guide: AAPC

- Introduce self.
- This is independent, unfunded, non-commissioned research.
- The dissertation will be in the public domain if a degree is awarded.
- The research is looking at the factors influencing social workers and team managers - constraints and realities – when contemplating use of adult protection policies to protect older people from abuse.
- Explain issues to be covered:
  - Respondent's role, experience, background
  - Topic areas
- Explain use of transcripts (researcher access only, maybe university)
- Anonymity of responses given. Elders' names or identity is neither sought nor required.
- Confirm mutual duty of care to report any serious concerns that may emerge that have, will or may put an elder at risk. (Confidentiality is not therefore absolute).
- Questions? Can stop interview at any point without giving a reason.
- Confirm informed consent. Each participant sign consent sheet.

---

1. Why are referral rates lower here for older people than other vulnerable adults?
2. How can your work here raise the quality of care for older people in care homes?
3. How does your work and learning connect up with domestic violence and the other public protections forums?
4. Your adult protection framework is multi-agency – statutory services, law enforcement, regulators, commissioners and so on. What has been the key learning about how to protect and safeguard older people from abuse in (Authority)?
5. From where you sit, what difference has the policy and procedures made to practice?

## Appendix 8 Vignettes & topic guide (team managers)

### *Vignettes*

1. You've just taken over the care management of Mrs Longley, a 78 year old woman who lives alone. The lady has been known to social services / EMI services for about ten years. Mrs Longley's son has substance misuse problems and criminal convictions for violence as well as mental health problems. He has taken money from Mrs L, has pushed, shoved and threatened her and damaged her property in the past, but she has always refused to press charges. Mrs Longley has just told her CPN that her son is demanding money and threatening her again. Mrs Longley refuses to stop him coming to the house, as she likes his company and help in the house. What would you do?

2. The manager of a home care service phones you about Mrs Roberts. Mr and Mrs Roberts live in their own home. Mrs Roberts has dementia. The couple have home care assistance to help Mrs Roberts get up and go to bed and wash. The home carer has reported that Mrs Roberts has bruising on her arms and has recently become very timid and frightened. The home carer says Mr Roberts shouts and swears at his wife and says he'll "put her away". What would you do?

3. You are doing a regular review of Miss Llewellyn's care plan and placement in a care home. Miss Llewellyn has bi-polar disorder. Before the review starts, she tells you she saw one of the staff walking behind another resident and thrusting his pelvis in a sexually suggestive way. She said he was doing it to her too. What would you do?

4. Mr Littlemore's daughter gets her father's pensions cashed and does all his shopping, cooking and cleaning. His son, who lives a hundred miles away, phones you to say how worried he is after his recent visit. His dad had lost weight, was dishevelled, dirty and seemed depressed, and his cupboards were empty. He was living in one room where he slept and washed. The son says his dad's sizeable civil service pension and state pension are more than adequate for his needs. The son and his sister don't get on. What would you do?

## *Topic guide using vignettes: team managers*

*This was used twice only with team managers, before revision to omit the vignettes.*

- Introduce self.
- This is independent, unfunded, non-commissioned research.
- The dissertation will be in the public domain if a degree is awarded.
- The research is looking at the factors influencing social workers and team managers - constraints and realities – when contemplating use of adult protection policies to protect older people from abuse.
- Explain issues to be covered:
- Respondent's role, experience, background
- Topic areas
- Explain use of transcripts (researcher access only, maybe university)
- Anonymity of responses given. Elders' names or identity is neither sought nor required.
- Confirm mutual duty of care to report any serious concerns that may emerge that have, will or may put an elder at risk. (Confidentiality is not therefore absolute).
- Questions? Can stop interview at any point without giving a reason.
- Permission to tape interview?
- Confirm informed consent. Participant sign consent sheet.

---

**1. Your work with older people**

Current/past. Settings, experience.

**2. Vignettes – how would you respond…**

**3. Tell me about your experience of dealing with alerts or concerns about an older person under the adult protection procedures**

*Describe some cases – where procedures used, not used.*

*What sort of things were you factoring into your decision-making? Probe – thresholds for intervention.*

*Why are referral rates lower here for older people than other vulnerable adults?*

*Domestic abuse – examples?*

**4. How much discretion would you say you have when dealing with alerts?**

*Examples*

**5. Sometimes the quality of services older people receive is poor, what do you do if you encounter this?**

*Probe – challenge, organisational expectation/permission*

**6. Your view of the adult protection procedures – how far have they helped or hindered you in adult protection of older people?**

**End. Thanks**

# Appendix 9 Contact summary form

*Complete straight after write up done*

**Interview/conversation/focus group/committee/other**

**Contact date** **Today's date**

**1 Main issues /themes that struck you**

**2. Summarise info you got & failed to get**

**3 Anything else that struck you as salient, interesting, important, illuminating?**

**4. What things have you got to do/think about/find out?**

# Appendix 10 Case analysis form

*Do 1/3 way in then repeat whenever*

Date completed:

1. **themes, impressions**

2. **speculations, hypotheses**

3. **alternative explanations – self challenge**

4. **so what? – next steps**

# Appendix 11 Case themes form

Date completed:

Fieldwork stage:

**Purpose:** identify themes and narrative so far

## Appendix 12 Document summary form

**Document Summary Form**

Doc number:

Site:

Doc title:

Date supplied:

Who supplied:

Status (public/inter-agency/one agency/confidential/statutory req/other):

Intended audience:

Purpose:

Importance of doc to project (link with key words):

Brief summary:

Link with other docs (cross reference by code):

Link with research questions/analytic codes: